Disposition of Comments Organized by Theme

Draft Version of the *APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update*

Available for public comment from September 20, 2024, to November 19, 2024.

Introduction

The panel is grateful to the many individuals and groups that took the time to share their helpful feedback on this guideline document, which updates APA's (2017) *Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults*. Over 600 individuals/groups submitted comments. All comments were reviewed by the guideline update panel and the panel revised the document as appropriate. Responses to comments are below, organized by theme. When there were multiple comments expressing the same point, a response to the group of comments is provided and responders are referred to that response. If the panel believed that a comment justified a change to the guideline document, a change was made and indicated in the response to the comment; if the panel believed a change was not justified, the panel explained in the response its reasoning.

Responses to the first public comment period for this guideline along with additional information about APA's development of clinical practice guidelines can be found at the following link: APA clinical practice guideline website.

Please note, while the panel attempted to specify the page numbers of edits in the guideline document, these page numbers may have changes in the final formatting of the guideline. Please use the page number as an approximation for the location of the change.

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Section 1: Overall Comments on APA's Updated PTSD Guideline

Commenter (Group or Individual?)	Section	Comment	Panel Response
Judith Herman (Individual)	Treatment Recommendations	I find it hard to understand why the APA has invested so much time and energy updating these guidelines, when the methodology employed was so restrictive that excluding any treatments other than those already established was basically a foregone conclusion. Even EMDR is given only conditional recommendattion. Really? In the future I would strongly suggest a much fuller discussion of a the widely-recogmized limitations of these established treatments, and a section devoted to a full discussion of promising and innovative treatments that have a strong evidence-base but may not yet meet the most rigorous inclusion criteria.	Thank you for raising this question. Clinical Practice Guidelines by their definition and design use the rigorous methodology you note; the strengths and limitations of this methodology are noted throughout the report. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria. The Advisory Steering Committee that oversees APA's clinical practice guidelines will have further discussion on APA's approach as it continues to examine best practices.
Mary Burke (Individual)	Treatment Recommendations	In addition, substance use disorders and sleep disorders, especially nightmares and insomnia, need to be addressed at the outset of treatment for PTSD. These tw conditoins will siognificantly impede recovery from PTSD and lead to more prolonged symptoms and psychiatric syndromes	Thank you for highlighting the essential role of substance use and sleep disorders in PTSD treatment. We agree that these conditions must be addressed at the start of PTSD care, as they are often deeply intertwined with the disorder's persistence and intensity.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Carl Grahn (Individual)	Treatment Recommendations	Please stop recommending that all people need to automatically complete stage 2 trauma treatments! Most people with PTSD have more than one trauma event, meet the criteria/qualifications for complex PTSD, and have co-occurring disorders (such as addictions and/or mood disorders). Therefore, a transdiagnostic approach that compliments a stage 1 trauma treatment should be recommended as a primary referral initially (such as ACT, DBT, Seeking Safety, Mindfulness-based approaches, STAIR, CBT for Depression, etc.) to ensure that clients are PREPARED for stage 2 trauma treatments (such as CPT, PE, COPE, or WET). There is research about readiness for stage 2 trauma treatments that include indicators that someone is ready for stage 2 treatments (such as consistent multiple coping skills usage, reduced/sobriety from addictive substances/behaviors, adequate healthy social support, and readiness to engage in trauma treatment with informed consent). References • Acierno, R., Resnick, H., Kilpatrick, D. G., Saunders, B., & Best, C. L. (1999). Risk factors for rape, physical assault, and posttraumatic stress disorder in women: Examination of differential multivariate relationships. Journal of anxiety disorders, 13(6), 541–563. • American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing. • Back, S. E., Dansky, B. S., Carroll, K. M., Foa, E. B., & Brady, K. T. (2001). Exposure therapy in the treatment	Thank you for your comment. This is interesting feedback. The recommendations emerge from the data reviewed - The methodology used to update the PTSD Guidelines is not predicated on any assumptions about stages of treatment, transdiagnostic or undiagnostic, nor number of traumas. The results are based on the inclusion criteria. The sequencing of treatment is addressed in the introduction of the text but is not the focus of this task. However, APA has recently approved two professional practice guidelines that compliment this clinical practice guideline: one on the treatment of adults with PTSD and traumatic stress (APA, 2021a) and another one on the treatment of complex PTSD (APA, 2021b) which focuses on the process of treatment that addresses these specific concerns.

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		behaviors, 80, 28–33. doi: 10.1016/j.addbeh.2017.12.026	
Kristi Pruiksma (Individual)	Definition of the Problem	the last line of page 33 states " PTSD is characterized by 20 symptoms across four symptom clusters, 565 specifically: re-experiencing". However, my understanding is that DSM-5 moved away from the term "re-experiencing" and instead uses "intrusions" on purpose because when people have these symptoms they are not actually re-experiencing the trauma. I suggest using language consistent with DSM-5	Thank you for your comment. We have made this edit in the document.
Felicia Smith (Individual)	Treatment Recommendations	As I read through the document, I am surprised that there is no reference to use of medical cannibas in the treatment of PTSD. Nearly 30 states (if not more) have legalized its use for the medical treatment of PTSD. This law goes into effect in KY in Jan 2025, which drives my interest on the topic. APA should be a leader in providing guidance on practice guidelines for this line of treatment. If the research on the topic is inconclusive, then it would be prudent to present that information in this document. Failing to address the medical use of marijuana for the treatment of PTSD would be a missed opportunity for APA to speak on a topic that is very relevant in society today.	Thank you for your comment. Though the systematic reviews did not identify cannabis interventions, a comment was added in the Recommendations for Research section noting that more research is needed on cannabis interventions for the treatment of PTSD.
Allison Gillens (Group: APA CECP)	General Comment + References	Regarding non-pharmacological treatments for PTSD, a brief discussion of alternative therapies (e.g., rTMS, equine assisted therapy) would be prudent. Additional references to consider: Garcia, H. A., McGeary, C. A., Finley, E. P., McGeary, D. D., Ketchum, N. S., & Peterson, A. L. (2016). The influence of trauma and patient characteristics on provider burnout in VA	Given the high number of treatments that exist that do not meet the inclusion criteria, the panel was concerned about naming or mentioning any emerging treatments that have not yet met inclusion criteria whether pharmacological or not. It would be impossible to name all of the therapies

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		post‐traumatic stress disorder specialty programmes. Psychology and Psychotherapy: Theory, Research and Practice, 89(1), 66–81. https://doi.org/10.1111/papt.12057 McGuinness, A. G. (2024). Integrative and Holistic Approaches to Treating PTSD: Two Theoretical Models to Guide Best Practice. Tsai, J., Shen, J., Southwick, S. M., Greenberg, S., Pluta, A., & Pietrzak, R. H. (2018). Public attitudes and literacy about posttraumatic stress disorder in U.S. adults. Journal of anxiety disorders, 55, 63–69. https://doi.org/10.1016/j.janxdis.2018.02.002	in development in a manner that would be equitable, comprehensive and accurate.
Allison Gillens (Group: APA CECP)	Considerations for Treatment Implementation	• Page 66-line 1274 – Following completion of the above paragraph, it would be prudent to make clear the shared role of patient and therapist in mitigating and monitoring the risk to the patient's wellbeing. Including an explicit discussion surrounding how distress, mood, and safety risk will be measured, the limitations of therapist availability, and resources should arise. Additionally, the patient should be made aware of their right to request a different provider if they feel their needs would best be served by someone else. • Page 68-line 1315 – "communication with patients, their families, and their care team". Given the known importance of a holistic approach to PTSD care (McGuinness, 2024), the importance of communication between all stakeholders should be noted.	Thank you for your review and feedback. Bullet #1: Thank you for noting this. There are several areas within the document that speak to the points you are raising within the implementation considerations section. Bullet #2: Thank you for your suggestion. This edit was made and the citation was added into the document. Bullet #3: Thank you for noting this important point. The Panel expanded the existing note on the affordability of receiving care in the barriers to treatment section by citing the PPG for

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		• Page 69 line 1357 – the loss of income in order to engage in treatment should be listed given this is oft forgotten as a barrier to care. i.e., "Examples include costs that exceed the ability to pay, loss of income in order to engage in treatment…" • Page 70 line 1373 – consider adding "and poor public literacy surrounding PTSD treatments in first world countries represent another barrier (Tsai et al., 2018). • Page 77 line 1557 – Additional consideration should be given to the mental health of the provider, with the onus being on the provider to recognize if provider burnout or mental health at that time may hinder the provision of high-quality PTSD specialty care (Garcia et al., 2016). Provider wellbeing should be an important consideration in the treatment of PTSD. • Page 78 – Line 1565 "Monitoring Treatment Response" – it may behoove the APA to delineate if certain comorbidities would benefit from being addressed prior to engagement in PTSD treatment and/or which comorbidities would benefit from being treated simultaneously (e.g., psychosis, severe substance use disorders, self-harm etc) • Page 97 – If available, a line discussing evidence-based approaches to selection of the various modalities of treatment (CPT, PE, EMDR) would be greatly helpful.	psychological practice for people with low-income and economic marginalization. Further, decision aids are developed for each finalized CPG, and one will be developed for this CPG that will include links to APA's PPGs for working with specific populations to better integrate all the guidelines and more as part of evidence-based practice. Bullet #4: Thank you for this suggestion. The Tsai et al 2018 cite has been added to the existing discussion on mental health literacy in the barriers to treatment section. It is outside the scope of the Panel's work to further examine this area. Bullet #5: Thank you for the suggestion. The Garcia et al. (2016) cite has been added to the existing bullet point in the implementation considerations section that health and mental health systems also need to be mindful of clinician burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue. Bullet #6 & 7: Thank you for this suggestion. While this point is outside the purview of the Panel's work, the Panel discusses in the document about the importance of competency and engaging in

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			shared decision-making between the therapist and patient.
Allison Gillens (Group: APA CECP)	Process and Methods for the CPG – Scoping	• Pages 41-42, Lines 743-750: Appreciation is noted for the discussion surrounding PTSD and C-PTSD diagnosis and how this related to differences in DSM-V and ICD diagnoses. Inclusion of dissociation as an important outcome appears to be a helpful and appropriate step to address this, especially with the consideration of implications of an international audience for this CPG. • Pages 42, Lines 751-766: The efforts to explain the discussions of appropriate scope, balancing interests in breadth vs. remaining focused in aims is valued and speaks to concerns consumers might have.	Thank you for the feedback.
Allison Gillens (Group: APA CECP)	Key Questions and Analytic Framework for the Systematic Reviews	Page 40, Line 710: "victims" – might consider alternate word given connotation of word and to reflect that PTSD (per DSM-V) may be diagnosed in persons with direct experience, witnessing, or learning a traumatic event has occurred to a close loved one.	The word "victims" is used to reflect persons who have experienced traumatic events directly as well as those who witnessed or learned that a traumatic event has happened to a loved one.
Allison Gillens (Group: APA CECP)	Treatment Outcomes Considered in the Guideline	• Page 38, Line 669: under "Treatment acceptability," it would be helpful to clarify meaning of "withdrawal" as compared to "dropout." • Thank you for the time and careful consideration that goes into a project like developing a CPG. Appreciation is noted for clarification throughout about basing recommendations in available, recent scientific literature and how this may not reflect full breadth of evidence. • With understanding of limitations of the review based on data availability, it may be helpful to discuss how service	Thank you for the feedback. We will clarify meaning of "withdrawal" and "dropout" as they have different meanings. We have also added in the document more information about group and telehealth delivery and systems level considerations.

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		delivery and systems level considerations impact PTSD interventions. For instance, there may be differences in individual, group, teletherapy services, as well as potential influence of the environment of care including trauma-informed practice. Further, for specific types of trauma (military/combat-related, medical), the environment of care (VA/DoD/military, hospital/medical) itself may be involve traumatic reminders. Finally, institutional support for clinicians providing PTSD interventions, especially for early career or other providers with a greater proportion of their role allocated to direct patient care, may be helpful to acknowledge given its role in provider burnout and potential for secondary victimization.	
Sheila Rauch (Individual)	General Comment	Prolonged Exposure for Primary Care is not mentioned? There is an RCT comparing it to Minimal attention control and another comparing it to TAU. Is this due to the use of a minimal attention control instead of waitlist or TAU? Or is it considered mPE? It would be good to note this specifically somewhere in the document. This is part of the problem with reliance on reviews as the authors noted in the discussion.	The methodology used to update the PTSD Guideline reviewed PE therapies as a group; therefore, PE for Primary Care is not mentioned specifically.
Sheila Rauch (Individual)	General Comment	Setting of clinical implementation is important and these CPGs do not provide enough attention to whether an intervention is supported for use in inpatient, primary care, outpatient specialty mental health, etc. In addition, massed versus spaced models of care are not discussed. It would be useful to discuss the state of the literature regarding these implementation variants.	Thank you for the suggestion. It would not be possible to discuss the state of the literature with respect to implementation as this is not the focus of the CPG.
Sheila Rauch (Individual)	Treatment Recommendations	Page 9, footnote: "Trauma-focused CBT refers to a broad grouping of therapies and not a specific therapy that include	Thank you for the suggestion- we will revise this section as suggested.

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		elements such as psychoeducation, cognitive restructuring, in vivo exposure, imaginal exposure, or trauma-focused coping." I think this statement should be revised for clarity to "CBT refers to a broad grouping of therapies that include elements such as psychoeducation, cognitive restructuring, in vivo exposure, imaginal exposure, or trauma-focused coping and not a specific therapy."	
Paula Schnurr (Individual)	Implementation Considerations	This section with numerous unofficial recommendations undermines the evidence-based approach to the guideline. I am well aware that the initial PTSD guideline upset many APA members because it was based only on scientific evidence that did not include practices that some providers use and believe are the most appropriate for trauma survivors, including psychodynamic and psychoanalytic approaches. For the VA/DoD guideline, we wrote a separate implementation paper (Lang et al., 2024, JTS) to achieve what I think you are attempting with this section. I suggest considering this option so that the content can be presented without adding so much unofficial recommendation content. In addition, a paper would be more visible, and presumably, impactful.	Thank you for your comments and suggestion about separating out the Implementation Considerations section of the guideline. In including this section in the guideline, it is hoped that the panel can better contextualize the traditional recommendations and offer advice to enhance clinical utility and uptake. This section also allows for other types of evidence and clinical expertise to be integrated as part of the broader evidence-based practice. To avoid confusion with the development method for the traditional recommendations however, a note is included prominently at the top of this section noting that the implementation considerations are based on expert consensus or review of unrestricted scholarly literature, including observational studies and thus that the included information is obtained through a less rigorous process but aims to capture current professional wisdom.

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Paula Schnurr (Individual)	Executive Summary	The Executive Summary indicates that the guideline is based on 15 reviews but this text indicates that Pim Cuijpers carried out additional meta-analyses. Details about his contribution should be added, and the reasons for these additional analyses should be provided.	Thank you for your comment. We added clarification to the document that data was pulled from the National Center for PTSD's PTSD Repository and the Meta-Analytic Database of Psychotherapy Trials. This data was used to inform the panel whether there were any new high-quality studies that were published after the first wave of literature searches on interventions that were underrepresented across the existing systematic reviews / meta-analyses (e.g., psychodynamic) and would potentially alter Panel recommendations. A meta-analysis with additional studies was performed by Dr. Cuijpers and his team. It was determined that this new data would not alter existing recommendations. We also added additional information in Appendix K of the guideline that further details the data analyses pulled from the National Center for PTSD.
Paula Schnurr (Individual)	Scoping	It would be helpful to know why the workgroup did not consider telehealth delivery of the interventions included, which seems especially important in this post-COVID era.	The panel included in its PICOTS framework both telehealth and in-person interventions however the panel was limited to the studies that were identified across the systematic reviews and meta-analyses.
Paula Schnurr (Individual)	Critical Outcomes	I could not find whether the workgroup limited the PTSD outcomes to those based on blinded clinician assessment or also included questionnaires.	This workgroup reviewed PTSD outcomes based on both blinded clinician assessment and questionnaires.

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Paula Schnurr (Individual)	Introduction	I do not believe it is true that there is less funding for psychotherapy research than pharmacological research in PTSD. There have been far fewer medication trials relative to psychotherapy trials, and in fact, this is a limit of the pharma data, most of which is quite old.	Thank you for your comment. NIMH funding can be hard to obtain for psychotherapy trials due to its objective, targeted mechanism approach and lack of known biomarkers associated with psychotherapy mechanisms. An additional funding resource available for pharmacological research is funding from pharmaceutical companies, though this is often limited by potential financial benefit. The funding available through the VA Health Care System is potentially different and not easily accessible to researchers outside of the VA. The panel will look to tweak wording in this section of the document on this issue.
Paula Schnurr (Individual)	General Comment	Given the stated lack of information about adverse events in psychotherapy trials and the resulting quality of evidence, which is stated to be very low, it is not clear how the evidence for any psychotherapy intervention could be rated as anything other that low according to the GRADE framework that was used. It would be helpful to specify throughout how the SOE for any psychotherapy intervention is not low, e.g., how was the SOE for PE, CPT, and TFCBT moderate to high?	Thank you for the feedback. The panel referred to the Strength of Evidence (SOE) / GRADE ratings conducted by the authors of each of the fifteen systematic reviews / meta-analyses (if they were available); the Panel itself did not conduct the SOE / GRADE ratings. The systematic review / meta-analyses' SOE/GRADE ratings along with its benefits and harms/burdens data that the review reported and the Panel's review of outside literature and documented clinician and patient experiences on patients' values and preferences and applicability of the intervention that were used to develop its recommendation statements

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			can be found in the supplemental Excel file Appendix J.
Amanda Devane (Individual)	General Comment	I am glad to see APA is providing this update. As a provider in a community clinic, I offer CPT and PE to my patients and find extremely positive results. My patients feel significant hope and confidence being provided treatments that have been shown to work time and time again, with data from our own clinic backing these scientific findings. I think research into the efficacy of treatments for PTSD is nascent and have no doubt that further research into other treatment options will provide clearer results which will be incorporated into future iterations of the Guidelines. For now, I am very happy to see that CPT and PE continue to offer strong results and continue to be highly recommended.	Thank you for your comment.
Thomas Bivona (Individual)	General Comment	PET and CPT have been established by the VA as gold-standard treatments for PTSD for some time, and I am encouraged that the proposed recommendations include them as first-line interventions. It is noteworthy that EMDR is absent from this category, as it has shown effectiveness in treating PTSD. However, I don't think anyone will disagree with the statement that EMDR is a controversial treatment. Given EMDR's controversial nature, as well as the debate over whether bilateral stimulation is a necessary or effective part of successful PTSD treatment, I am glad it is considered a second-line treatment in these proposed guidelines. I support the proposed first-line treatment recommendations	Thank you for your comment.
Andrew Bland (Group: Society for Humanistic	General Comment	We appreciate that the Guideline Update Panel has:	Thank you for your feedback.

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Psychology [Division 32 of APA])		• accounted for complex PTSD despite its continued omission from the DSM-5-TR in 2021. • incorporated the need for clinicians (a) to be mindful of "the potential relevance of key identities such as race, ethnicity, class, gender, sexual orientation, disability, religion, intersecting identities, etc." and (b) to engage in cultural humility and to adapt treatment accordingly in order to "enhance treatment acceptability and effectiveness" (p. 24). • stressed "the critical role of a strong therapeutic alliance as well as the importance of harnessing key change processes" such as bracketing "assumptions and beliefs about trauma, recovery, and how these can affect the therapeutic relationship, treatment selection, and implementation" (p. 26). • included qualitative methods as legitimate forms of research for future systematic reviews (pp. 5, 28, 100). To build upon these improvements, we also have several suggestions for the Clinical Practice Guidelines.	
Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	First, the 2024 update to the APA Professional Practice Guidelines for PTSD—which the Update Panel acknowledged their familiarity with (p. 6)—offered substantial improvements upon the serious limitations of 2017 Clinical Practice Guidelines for PTSD (see Psychotherapy, Vol. 56, Issue 3, 2019; Dauphin, 2020). We find ourselves perplexed that this update to the Clinical Practice Guidelines does not also incorporate those enhancements, which include:	Thank you for your comment. APA produces two different types of guidelines which are intended to address different areas but be complementary to each other. Professional practice guidelines (PPGs) address psychological practice with particular populations or areas and are intended for psychologists. Clinical practice guidelines (CPGs)

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		• extending the focus of trauma work "beyond symptoms/diagnosis to understand and enhance adaptive biopsychosocial functioning, resilience, and quality of life." • basing "assessment, … clinical decision-making, [and] evidence-informed treatment interventions" in response to trauma on an "individualized, client-centered, collaborative basis." • accounting for "factors to establish and strengthen the therapeutic alliance, client engagement and safety, professional boundaries, and fully comprehensive services." • expanding the definition of trauma beyond a principally biomedical diagnosis to also include interpersonal, developmental, racial, vicarious, intergenerational, and collective trauma. • directly addressing issues involving intersectionality, oppression, inequity, and health disparities, as well as interpersonal violence as an artifact of trauma. • acknowledging the relevance of relational dimensions of trauma as well as relational and somatic healing approaches to complement cognitive- and exposure-oriented therapies. It is worth noting (a) the decades-long history of those approaches in psychology and their centuries-long history in other-than-Western, Educated, Industrialized, Rich, and Democratic (WEIRD) societies and (b) their incorporation in third-wave CBT, which is now common fare for several other conditions.	focus on specific disorders, treatments, and outcomes, are informed by systematic reviews/meta-analyses of the literature and are intended for a wide audience. The PPG on PTSD is intended to be complementary to the CPG but with a different focus per the differences between PPGs and CPGs. Please refer to the new type of recommendations section added called Implementation Considerations for recommendations regarding contextual factors and implementation, the change process section, and the discussion section for a broader discussion of trauma and considerations. APA has made several changes to its CPG development since the original PTSD CPG in 2017. The purpose of these changes was to include greater focus on context, diversity, and interpersonal change processes. These changes include: • Originally, there was only one type of recommendation – i.e. whether a treatment works (efficacy) and how well it works compared to other active treatments (comparative effectiveness). APA added two additional types of recommendations: a. Implementation considerations which focus on the context (e.g. diversity), change processes, etc.

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		• encouraging familiarity with research on relational and common factors, therapeutic presence and responsiveness, etc. to "add critical nuance" to understanding therapeutic effectiveness. • emphasizing the role of honoring clients' preferences to promote self-determination and empowerment. • recognizing the relevance of practice-based evidence to inform evidence-based practice. • incorporating moral injury as an outcome of trauma. • articulating the need for psychologists to employ creativity and innovation to meet new demands in recent years. We believe that the Clinical Practice Guidelines would be greatly enriched by better accounting for the substantive literature base in each of these areas that is referenced throughout the updated Professional Practice Guidelines.	b. Research recommendations which focus on gaps in the scientific literature. • APA also included discussion of change processes and more information in both the guideline documents and appendices on contextual considerations (e.g., diversity of the included samples in the reviewed research). Further, the CPG development panel took the perspectives and concerns of members seriously. In addition to the changes noted above, this updated CPG: a. Considered 15 systematic reviews of the literature in order to include as broad a vista of the research literature as possible within the IOM standards. In comparison, the original 2017 CPG on PTSD used only one systematic review. b. Included more attention to generalizability of recommendations to different populations (e.g., diverse identities, traumas, comorbidities, and settings). c. Considered research about complex PTSD. d. Included two new types of recommendations (implementation considerations and research recommendations) as well as efficacy recommendations that broaden the scope from the original CPG (e.g., on comorbid substance use disorders, complimentary & integrative health treatments, pharmacological augmentation,

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			psychedelics in PTSD treatment, etc.). e. Included some changes in recommendations for treatments. f. Broadened the quality-of-life outcomes to also include functional outcomes such as work, social/interpersonal, home, and return to work or active duty.
Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	Second, we advise drawing greater attention to the limitations of the three therapies that the Update Panel "recommends" as frontline treatments for trauma (p. 9)—and, with that, to the need to honor clients' preferences (Rubenstein et al., 2024). While we do not doubt that these modalities are effective in some circumstances, it is worth noting that the unhelpful aspects of exposure therapy were highlighted in a special section of American Psychologist earlier this year (Vol. 79, Issue 3, 2024), and other sources (e.g., Briere, 2019; Levine, 1997; Serlin et al., 2019) have stressed its potentially harmful, retraumatizing effects. Likewise, researchers have questioned Cognitive Processing Therapy's longitudinal effectiveness (Steenkamp et al., 2015) and its superiority over other therapies (Steenkamp et al., 2020), including models that the Update Panel claims have "insufficient evidence" (p. 11). Further, the developers of trauma-focused CBT have admitted that it can be ineffective for complex PTSD in children (Amaya-Jackson & Derosa, 2007)—and, not surprisingly, that outcome also has been found in adults (Lonergan, 2014).	The CPGs comment on the limitations of the therapeutic modalities discussed.
Andrew Bland (Group: Society	General Comment	That said, third, though the Clinical Practice Guidelines suggest the need for clinicians' familiarity with the biological,	These are interesting points but are not the focus of the Clinical Practice Guidelines.

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for Humanistic Psychology [Division 32 of APA])		psychological, and social/cultural impacts of trauma, we recommend that they more explicitly address the relevance of a holistic, integrated conceptualization that better accounts for the interaction between those dimensions. For example, Frankl's (2004), May's (1983), and van Deurzen's (2012) dimensional ontologies emphasize the interplay between endogenic/umwelt (biological), psychogenic/eigenwelt (individual psychological development), sociogenic/mitwelt (socio-cultural), and noögenic/überwelt (spiritual) factors grounded in meaning making. Also, Sheldon's (2004) integral model moves from biologically based levels of analysis to higher, socially based levels and demonstrates the role of active individual and collective integration in working toward optimal well-being. These serve as alternatives to the limitations of the biopsychosocial model (Henriques, 2015). In addition, the Clinical Practice Guidelines could take the lead on referring to trauma as an "injury" (versus a disorder). Doing so is not only less pathologizing but also accounts for trauma being an emotional, relational, and spiritual wound that is amenable to healing attention and transformation (Joseph, 2021; Levine, 2010). In turn, we also believe that, beyond symptom reduction (first-order change—which we certainly acknowledge the value of), more attention could be given to transformative second-order change (Fraser & Solovey, 2007) that enables people to engage deeply with questions of meaning in their suffering (Cameron, 2019; Merriman-Khanna, 2018; Serlin et al., 2019) in the interest of prevention (versus external intervention).	

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Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	That said, we also recommend more discussion about the potential for resilience and post-traumatic growth in clients (Joseph, 2021; Tedeschi & Moore, 2021) to enhance the definition of quality-of-life outcomes (as called for by the Update Panel on p. 29). It also seems that the Update Panel's focus on symptom reduction as the principal goal may play into their observation about the limited effectiveness of mindfulness interventions, which are intended more for promoting acceptance of emotional experiencing (Lindsay & Creswell, 2019). To that point, we also question the Update Panel's conclusion that emotion-focused therapy has "insufficient" research evidence (p. 11) in light of studies that demonstrate its perceived helpfulness by clients for working with the depth of their suffering, its conduciveness to reducing incoherence and enhancing depth of experiencing and, with that, empathetic responding (see Khayyat-Abuaita & Paivio, 2019). On that note, we also find it troublesome that the Update Committee altogether omitted person-centered therapy for trauma—the efficacy/effectiveness of which is summarized by Venter (2024), including its comparable outcomes with cognitive/behavioral treatments, as well as in common factors research (Elkins, 2022). Importantly, though we understand that relatively fewer studies may be available for these therapies in the way of symptom reduction alone, we find the implications of the term "insufficient evidence" language problematic insofar as it can be and has been taken up by insurance companies to mean that the therapies are ineffective and even unscientific and, therefore, clinicians who employ them should not be reimbursed.	Treatments and outcomes were determined by the Clinical Practice Guideline methodology. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria.

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Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	Fourth, to add to the Professional Practice Guidelines' aforementioned recognition of the value of relational and somatic healing methods (see Kinsler, 2018; Stanley, 2016) that are omitted from the Clinical Practice Guidelines, we recommend that expressive modalities for healing trauma (see de la Prida, 2024; Serlin et al., 2019) also be included—the effectiveness of which for people of color has been emphasized by APA's immediate past-president, Thema Bryant (Bryant-Davis, 2019).	Treatments and outcomes were determined by the Clinical Practice Guideline methodology. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria.
Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	Fifth, although the Clinical Practice Guidelines acknowledge the contributions of qualitative research and the need for cultural competence and humility (as aforementioned), the research selected to inform the Guidelines is almost exclusively statistical and objectivist (etic) at the expense of subjectively- and intersubjectively lived context (emic). Certainly, quantitative methods are helpful and encouraged. On the other hand, we believe that greater emphasis on culturally and contextually informed and -congruent epistemological and methodological diversity is more conducive to greater understanding and appreciation of the complexity, depth, and nuance of the lived experience of and relational and bio-psycho-social-spiritual processes involved in trauma and possibilities for healing and helping. The intentional development of culturally accountable and community-defined practices also can prevent the Clinical Practice Guidelines from (a) becoming perceived by some (especially marginalized and oppressed	Thank you for your comment. While the research used to inform the potential benefits of a treatment is primarily quantitative, there are several factors that are part of decision-making in which other types of information such as clinician and patient expertise and experience is invited: when informing potential harms as well as patients' values and preferences regarding treatments. This information is provided by clinician and community (patient representative) members of the panel. To your broader point however, the Advisory Steering Committee (ASC) that oversees the initiative is very interested in further incorporating qualitative information into future CPGs. The ASC worked with APA staff to submit a proposal to the Agency for Healthcare Research and Quality to fund an innovative review

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		individuals/communities) as forms of manipulation, patronization, or colonization or (b) becoming implicated in the development of perspectives and/or practices that are unhelpful or even harmful for those they are intended to serve.	that would incorporate qualitative literature to inform an update of APA's depression CPG. This nomination was awarded funding and the ASC is looking forward to this.
Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	To that point, sixth, Bryant-Davis (2019) stressed the importance of culturally responsive trauma models that honor intersecting cultural contexts and sociopolitical histories of survivors and their communities. By extending beyond culture-bound PTSD treatments that focus on individuals' feelings, thoughts, and behaviors—and which thusly support a capitalistic, bureaucratic, medicalized status quo—clinicians may better attend to the soul and culture of those who have been systematically invalidated. Again, we appreciate that the updated Clinical Practice Guidelines have paid lip service to this (as aforementioned). Going forward, we also believe that the Update Panel could better heed the recommendations called for in Bryant-Davis's article.	The panel's inclusion of text about cultural syndromes is more than lip service. Again, the Clinical Practice Guideline methodology determines the outcome and future studies are encouraged so that future PICOTS could include cultural syndromes and RCTs use cultural treatment. Please also see the Implementation Considerations and Discussion sections of the document for further discussion of this topic.
Andrew Bland (Group: Society for Humanistic Psychology [Division 32 of APA])	General Comment	Seventh, the Clinical Practice Guidelines omit the potentially traumatizing outcomes of the COVID pandemic, which are accounted for in the Professional Practice Guidelines. In light of the U.S. Surgeon General (2023) having recently declared loneliness a public health crisis, consider also including the role of, especially, relational trauma in loneliness (Malli et al., 2023).	Treatments and outcomes were determined by the Clinical Practice Guideline methodology.
Andrew Bland (Group: Society for Humanistic Psychology	General Comment	Finally, we appreciate the inclusion of patients/clients and their families as stakeholders of the Guidelines (p. 36). From there, in addition to people's families, consider also including their communities to better convey possibilities for systemic	Thank you for your review.

Commenter (Group or Individual?)	Section	Comment	Panel Response
[Division 32 of APA])		change. Doing so better acknowledges the synergistic relationship between quality of life in individuals and in communities. **References** Amaya-Jackson, L., & Derosa, R. R. (2007). Treatment considerations for clinicians in applying evidence-based practice to complex presentations in child trauma. Journal of Trauma Stress, 20(4), 379-390. https://doi.org/10.1002/jts.20266 Briere, J. (2019, September 28). Reconsidering trauma: Treatment advances, relational issues, and mindfulness [Keynote address]. East Meets West in Psychotherapy Conference, Philadelphia, PA, United States. Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. Psychotherapy, 56(3), 400–408. https://doi.org/10.1037/pst0000241 Cameron, A. (2019). Trauma-focused presence. Journal of Humanistic Psychology. Advance online publication. https://doi.org/10.1177/0022167819880653 Dauphin, V. B. (2020). A critique of the American Psychological Association Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. Psychoanalytic	

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		centered therapy and counseling (3rd ed., pp. 374-387). Bloomsbury.	
Stewart Cooper (Group: Committee for the Advancement of General Applied Psychology [CAGAP])	General Comment	The Committee for the Advancement of General Applied Psychology has reviewed the APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder PTSD) in Adults – 2024 Update. The Guideline Update Panel for the Treatment of PTSD in Adults is to be commended for the quality of their work. The 2024 update provides the integration of additional and new research and increases the scientific basis for a number of evidence supported interventions.	Thank you for your review and feedback.
Robert Cuyler (Individual)	General Comment	The methodology used for the review of evidence exhibits a bias towards legacy therapies, particularly psychotherapies that focus on desensitization and/or reprocessing of traumatic memories. While these exposure-based psychotherapies are highly effective in clinical trials for treatment completers, reviews and critiques of available studies show substantial dropout rates linked primarily to intolerance of exposure to traumatic memories. [1] Furthermore, dropout rates in real world clinical settings are even more problematic (higher) than those observed in formal clinical trials. [2] Finally, access to mental health professionals in general, let alone experts in exposure-based psychotherapies is severely compromised by practitioner availability, geography, and affordability. Thus, the proposed updated guidelines miss an important opportunity by failing to highlight emerging, evidence-based therapies that offer enhanced tolerability and access, supported by published, peer-reviewed evidence. For these treatments, consideration of real world evidence is also	Thank you for your feedback. Treatments and outcomes were determined by the Clinical Practice Guideline methodology.

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		critical to validate actual outcomes (adherence and clinical benefit) vs. those obtained in formal clinical trials. Guidelines, such as proposed, should delineate clear pathways for emerging therapies that increase patient and practitioner treatment options and complement the existing recommended approaches. One such emerging treatment for PTSD is Capnometry-guided Respiratory Intervention, a prescription-based Class II Medical Device cleared by the FDA as an adjunctive treatment for PTSD [3,4]. Both clinical trials and published real world data report low dropout rates and clinically significant symptom reductions measured to six or twelve months post-treatment. Additionally, due to the care model, patient access is improved and clinician workload reduced. Steenkamp MM, Litz BT, Marmar CR. First-line psychotherapies for military-related PTSD. JAMA. 2020. 323(7):656–657. doi:10.1001/jama.2019.2082 Najavits LM. The problem of dropout from "gold standard" PTSD therapies. F1000Prime Rep. 2015 Apr 2;7:43. doi: 10.12703/P7-43. PMID: 26097716; PMCID: PMC4447050. Ostacher, M. J., Fischer, E., Bowen, E. R., Lyu, J., Robbins, D. J., & Suppes, T. (2021). Investigation of a capnometry guided respiratory intervention in treatment of posttraumatic stress disorder. Applied Psychophysiology and Biofeedback, 46, 367-376. https://doi.org/10.1007/s10484-021-09521-3 Cuyler, R. N., Katdare, R., Thomas, S., & Telch, M. J. (2022). Real-world outcomes of an innovative digital therapeutic for treatment of panic disorder and PTSD: A 1,500 patient effectiveness study. Frontiers inDigital Health, 4, 976001. https://doi.org/10.3389/fdgth.2022.976001	

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Anica Pless Kaiser (Group: The Stress Health and Aging Research Program [SHARP] at VA Boston Healthcare System)	General Comment	This is an excellent Guideline update that presents a wealth of information on the treatment of PTSD in adults in a concise way. Nevertheless, we believe that this update would benefit from adopting a life course perspective that recognizes a number of unique aging-related factors that may impact evidence-based treatment experiences for older people with PTSD. In addition, it seems important to us to consider including age as a diversity factor.	Thank you for your comment. The panel included additional information on select demographics that were reported within the 337 individual studies across the fifteen systematic reviews / meta-analyses, and this can be found in Appendix H of the guideline. Of the 337 unique studies that were identified across the fifteen systematic reviews / meta-analyses, 3 of them reported including participants aged 65 and older. The panel was limited to the data that was presented across the reviews and encourages the development of future reviews that focus on this important population.
Anica Pless Kaiser (Group: SHARP at VA Boston Healthcare System)	General Comment	1. The updated Guideline does not include aging terms (e.g., aging, aged, older, elderly) or considerations, with a few minor exceptions such as the mention of age as a demographic characteristic and the average age of participants within the reviews described. However, for the reviews that include adults over age 65, it was not mentioned if any looked at age-based subgroups or age-stratified analyses.	Treatments and outcomes were determined by the Clinical Practice Guideline methodology. The CPG did not investigate age-related differences in outcomes.
Anica Pless Kaiser (Group: SHARP at VA Boston Healthcare System)	General Comment	2. When describing the 15 reviews/meta-analyses reviewed by the panel, it is not clear if any of them had age-related comments or included studies focusing on older adults (those aged 65 and older).	Thank you for your comment. The panel included additional information on select demographics that were reported within the 337 individual studies across the fifteen systematic reviews / meta-analyses, and this can be found in Appendix H of the guideline. Of the 337 unique studies that

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			were identified across the fifteen systematic reviews / meta-analyses, 3 of them reported including participants aged 65 and older. The panel was limited to the data that was presented across the reviews and encourages the development of future reviews that focus on this important population.
Anica Pless Kaiser (Group: SHARP at VA Boston Healthcare System)	General Comment	3. Several parts of the Guideline mention the need for increasing diversity in research across areas, but omit older adults as an under-represented group and aging as an important diversity factor (e.g., lines 280-281 [research with diverse populations], 348-375 [key identities of people that may lead to treatment adaptations], 520-523 [future reviews should conduct sub-analyses by demographic factors when considering amount of evidence-based treatment received and treatment outcomes], 537-539 [call for future funding for treatment effectiveness studies with people who identify with various backgrounds/characteristics], 1278-82 [competence in culture and diversity], 1448-1450 [demographic characteristics related to differential treatment initiation], 1455 [treatment retention], 1492 [cultural competence]. a. Many of these places could benefit from the inclusion of aging-related considerations, mention, or at least a note about existing or needed research.	Thank you for your comment. The panel included additional information on select demographics that were reported within the 337 individual studies across the fifteen systematic reviews / meta-analyses, and this can be found in Appendix H of the guideline. Of the 337 unique studies that were identified across the fifteen systematic reviews / meta-analyses, 3 of them reported including participants aged 65 and older. The panel was limited to the data that was presented across the reviews and encourages the development of future reviews that focus on this important population.
Anica Pless Kaiser (Group: SHARP at VA	General Comment	5. Line 1330 in the "Barriers to Treatment" section – It may be worth mentioning the findings demonstrating that older adults are less likely to be offered psychotherapy or evidence-	5. Thank you for your comment, emphasis was added on this point in the barriers to treatment section.

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Boston Healthcare System)		based treatment for PTSD, and that older adults are more likely to complete psychotherapy once started than younger adults. 6. Will anything about age be included in Appendix H, "select demographic characteristics of studies reviewed"?	6.While the findings on this in the literature are mixed, Appendix H will include the mean age, percent female, percent of individuals who identify as Hispanic/Latino/a/e/x, and percent of individuals who identify as non-White.
Mike Mullette (Group: Lykos Therapeutics)	General Comment	Dear APA Panel: On behalf of Lykos Therapeutics, we would like to thank APA and this guidance committee for supporting and prioritizing patients with PTSD, demonstrated by your commitment to the review and update of the treatment guidelines. The amount of work to research, review and analyze the data is no small task and we thank the committee for their time, expertise and dedication. We have reviewed your feedback regarding the current research with MDMA and psychotherapy and appreciate your thoughtful comments. We look forward to contributing to moving forward integrating your feedback. Thank you again. Mike Mullette, Interim CEO & David Hough, MD Chief Medical Officer Lykos Therapeutics	Thank you for your feedback.
Julie Ording (Group: American College of Occupational and	General Comment	In general, APA appears to have clearly defined their focus, presented the background information succinctly, and addressed topics specifically relevant to treatment of PTSD in adults. Their data set is derived from a smaller set of references (approximately 246 by manual count, and based on 15 systematic reviews dated 2018-2024, as compared to	Thank you for your feedback.

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Environmental Medicine [ACOEM; Les Kertay, PhD, ABPP])		629 references that included 24 systematic reviews dated 2007-2017). The APA data set is more recent, and their scope is somewhat more restricted, which likely accounts for the differences in number of references. Nevertheless, the APA review addresses their stated scope thoroughly and with methodological rigor, and there are only limited differences in the recommendations (see below). Comparison is somewhat challenging in that the APA makes only affirmative recommendations for or against treatment, and all items with insufficient evidence contain no recommendation for or against; by contrast, some recommendations with insufficient evidence were stated in the ACOEM guideline.	
Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP])	Executive Summary – Background	Beginning with line 190, the GL cites PTSD as "one of the most highly prevalent psychiatric disorders" according to the DSM-5. I am unclear about the basis for this statement, given that despite widespread exposure to potentially traumatic events, the incidence in the general population as a whole is low, and certainly lower than depressive disorders, anxiety disorders, and some other categories. This is a minor point, but may be over-stating the case.	Thank you for your feedback. This sentence has been modified in the updated guideline document.
Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP])	Executive Summary – Background	The APA guideline does not address assessment tools, by contrast with the ACOEM GL. Given that the focus of the APA guideline was specifically on treatment, this may be a minor point but since assessment is a focus for psychology, and since diagnostic accuracy is important to effective treatment, APA may consider evaluating assessment tools, or making a comment regarding the importance of accurate diagnosis in its introduction.	Assessment tools were not part of the scope of the CPG. Treatments and outcomes were determined by the Clinical Practice Guideline methodology.

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Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP])	Treatment Recommendations – Psychological Interventions	The APA makes "strong for" recommendations (first line) for Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), and Trauma-Focused Cognitive Behavioral Therapy (CBT). These are generally consistent with the ACOEM guideline, though there is some variability in the level of evidence.	Thank you for your review.
Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP])	Treatment Recommendations – Complementary and Integrative Health Interventions	The APA guideline does not address the use of physical exercise, whereas the ACOEM guideline found B level evidence to support recommending it. Given the generally demonstrated efficacy of exercise in many psychiatric disorders, in some cases on par with psychotherapies and at least sometimes exceeding the efficacy of medications, the APA may want to considering addressing the issue in comment, if not in the evidence tables.	Treatments and outcomes were determined by the Clinical Practice Guideline methodology.
Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP])	Treatment Recommendations – Psychological Interventions	There were few other differences in recommendations for psychotherapeutic or psychoeducational methods. ACOEM considered some modalities that APA did not, and vice versa, but these differences are unlikely to have significant impact given that for both guidelines, there was a finding of insufficient evidence to recommend for or against.	Thank you for your review.
Jennifer Medicus (Group: American Psychiatric Association)	General Comment	The revised practice guideline is, in general, clearly written and provides excellent information related to the treatment of patients with PTSD. The sections on implementation and future research provide important context that complements the recommendations and discussion of guideline development methodologies. The sections on advocacy and equity, diversity, and inclusion are also very beneficial.	Thank you for your review.
Jennifer Medicus (Group:	Treatment Recommendations	One point that would be worthy of clarification or modification is the description of some treatments as "first-line" or "second-line". These descriptions coincide with	Thank you for taking the time to provide these helpful comments. We will add a note to further

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American Psychiatric Association)		whether the guideline statement is a recommendation or a suggestion. With the use of these phrases, readers might infer that a second-line treatment is indicated after a first-line treatment has been unsuccessful or not tolerated. However, the available evidence was not designed in this fashion. Alternatively, a reader might infer that a first-line treatment is always preferred over a second-line treatment as an initial step. This is particularly relevant to the first-line recommendation for CPT, PE, or trauma-focused CBT but second-line suggestion for several of the SSRIs or venlafaxine despite the later statement that "there is insufficient evidence for the Panel to recommend for or against SSRIs as a class over psychological therapy." Also, in terms of the logistical issues that are mentioned in the rationale of several of the statements, it is often impossible to find individuals who are skilled in delivering evidence-based psychotherapies in general and these listed psychotherapies in particular. Availability of psychotherapy is also influenced by systemic health inequities, financial and insurance limitations, geographic considerations, telehealth limitations, and other barriers. Availability of treatment with SSRIs and SNRIs is also influenced by those same factors but is typically more accessible than evidence-based psychotherapies.	explain and differentiate first and second line treatments. We agree with your note about the challenges with accessibility of some treatments and hope these recommendations can help to increase access to evidence based treatments.
Jennifer Medicus (Group: American	Treatment Recommendations	The use of the phrase "second-line" is especially confusing in the context of the statement on Seeking Safety vs. TAU in PTSD with comorbid SUD because it suggests against using Seeking Safety. Just glancing at the "second-line" level of the	Thank you for your comment. The panel re-visited its recommendation about Seeking Safety, re-examined the data and voted to change the recommendation as noted:

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Psychiatric Association)		statement would ordinarily suggest a treatment as a second line choice. The rationale for suggesting against Seeking Safety, rather than no recommendation, was not clear as the available evidence seemed to indicate that Seeking Safety and TAU were comparable in terms of benefits and harms/burdens. To specifically suggest against a treatment would ordinarily imply that either the benefits are less, or the harms are greater, or that other burdens outweigh the benefits, which does not seem to be true here.	**Level**: Other Treatments Reviewed **Recommendation Statement**: For patients with PTSD and comorbid SUD [substance use disorder], evidence indicates **no difference in effect** on PTSD symptoms or substance use for the following interventions **over a TAU for SUD intervention**. Thus, the panel makes **no recommendation** for or against the following interventions listed: ❖ Seeking Safety ❖ Seeking Safety plus TAU **Strength/Direction**: No difference in effect **Rationale**: Findings indicate no difference in effect for critical outcomes, no information or unclear effect on important outcomes. There was no evidence of differential harms/burdens although there is variability in the TAU category. The balance of benefits to harms/burdens is the same for seeking safety as control.
Jennifer Medicus (Group: American Psychiatric Association)	Treatment Recommendations	The statements that describe the "other treatments reviewed" provide context to the breadth and depth of the systematic review and the available evidence. They are less useful in providing readers with information about clinical care. They provide a listing of studied comparisons, however, there are many other comparisons that have not been studied	Thank you for taking the time to provide these helpful comments. We will add a note to further explain and differentiate first and second line treatments. We agree with your note about the challenges with accessibility of some treatments and hope

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		and would also be considered to have insufficient evidence as a result.	these recommendations can help to increase access to evidence based treatments.
Jennifer Medicus (Group: American Psychiatric Association)	Treatment Recommendations	The rationale of the statement on comparisons to other psychological interventions notes that "there is insufficient evidence to indicate that one is more effective than the other." To aid the clinician who may focus on the main recommendations and suggestions, it would help to add this to the rationale on the first- and second-line treatments, as well, so that it is clear that the options listed are comparable based on the available evidence.	Thank you for your comment. That section is intended to refer only to other treatments reviewed by the panel, but is not a comprehensive list of other treatments for which there is insufficient evidence. We will add a statement to clarify this point.
Jennifer Medicus (Group: American Psychiatric Association)	FAQs Document	The FAQ document provides a concise discussion of why psychodynamic treatment was not included. This information is also included in the guideline document, but appears in several sections, e.g., descriptions of literature search, future research. Because this is clearly a topic of significant interest for which the guideline group obviously gave much consideration, it may be useful to have a section on this in the text that is more easily found.	Thank you for this helpful suggestion. We will add this information more prominently in the document.
Jennifer Medicus (Group: American Psychiatric Association)	General Comment	The guideline document also describes the group's consideration of the important issue of complex PTSD; however, the guideline statements refer to PTSD and not C-PTSD. It would be helpful, even as a footnote, to describe whether the statements refer to C-PTSD as well as PTSD or whether they refer to PTSD only in the absence of robust treatment data that is specific to C-PTSD.	Thank you for your comment. We carefully discussed the DSM-5 and ICD-11 definitions of PTSD and the ICD-11 definition of complex PTSD in the document. We also included key important outcomes that addressed complex PTSD symptoms, and it was incorporated into the panel's decision making when developing the recommendations.

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Dr. Mirjam J Nijdam (Individual)	Treatment Recommendations and Appendix J	**Comment on Draft CPG Update for PTSD in Adults and on Appendix J** Dr Mirjam J Nijdam Licensed psychologist and Head of Research Track, ARQ National Psychotrauma Center, Diemen, Netherlands Assistant Professor, Amsterdam University Medical Centers, Amsterdam, Netherlands Thank you very much for allowing me to comment on the Draft Clinical Practice Guideline for PTSD in Adults. First of all, I would like to express appreciation of all the work you did and the evidence you reviewed for this update. I would like to make one comment specifically focused on Brief Eclectic Psychotherapy (BEP) and one more general comment: • The recommendation for BEP was 'conditional' in the 2017 guideline and is now 'insufficient evidence'. In the grid of Appendix J I see that only one study was identified on the primary outcome (Lindauer et al. 2004; I think this should read Lindauer et al., 2005) and that this was an important consideration in the recommendation. Next to this randomized controlled trial by Lindauer et al., two other randomized controlled trials have been conducted that report on PTSD symptom decline in BEPP against waitlist or minimal attention control conditions (Gersons et al., 2000; Schnyder et al., 2011; referenced in other fields of Appendix J) among which one by an independent research group. They have somewhat larger sample sizes than the study by Lindauer et al. so this should not be a reason to exclude them. I don't	Thank you for your review and feedback. Treatments and outcomes were determined by the Clinical Practice Guideline methodology. Since the publication of the original CPG, additional literature has been published on PTSD treatments. This new information has caused the panel to make a different recommendation for some treatments compared to the original CPG. Explanation about those decisions is in the 'rationale' section of the recommendations tables and the supplemental grid documenting the panel's decision-making.

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		know the reasons why these studies were not covered in the systematic reviews you included for the updated guideline, but I think these do contribute to the evidence on BEPP in an important way and it is important to make recommendations based on all available evidence. As in other guidelines for PTSD I see a tendency to recommend fewer treatments than in previous versions of the guideline. Cognitive therapy has for instance been moved from 'first-line' with 'strong' evidence to 'second-line' with 'conditional' evidence, Brief Eclectic Psychotherapy has been removed from 'second line' and 'conditional' evidence to 'insufficient evidence'. In addition, several (highly) efficacious emerging therapies have also received the predicate 'insufficient evidence' or were not included. I also miss a separate assessment of the evidence on virtual reality exposure therapies. This is a tendency in various guidelines, and also present in for instance the 2024 Department of Defence Clinical Practice Guideline for PTSD and ASD. I find it worrisome, as clinical service users and healthcare professionals may have a need for a different approach when the standard cognitive behavioural approaches do not have sufficient effect. Hoge, Chard and Yehuda (2024) make a similar point in their commentary on the DoD Clinical Practice Guideline. I therefore would make a plea for treatment recommendations that are based on the course and clinical symptoms of the disorder as there is evidence from network models that symptoms evolve over time. Examples of those recommendations have been put forward in recent staging	

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		approaches for PTSD (e.g., Nijdam, Vermetten, & McFarlane, 2023; Burback, Brémault-Philips, Nijdam, McFarlane & Vermetten, 2024).	
Robert Gangi (Individual)	General Comment	I am quite concerned, particularly as a clinician, but also as a research/practitioner- trained psychologist with the current development of PTSD treatment guidelines. Psychology has done a rather poor job coping with some of the inherent challenges of our subject of study. The PTSD guidelines are only a single example of this. The proposed guideline's reliance on research that prioritizes internal over external validity - apparent in the overreliance on exposure-based therapies and RCT's as their foundation- demonstrates once again that we are failing to meet our mandate not only to validly and rigorously study mind, but also to provide therapies for troubled patients that are based on our full and best efforts. A full and rigorous effort would rise to the epistemological challenge that is unique to our profession. We have chosen the daunting task of understanding consciousness and of helping others with its challenges and we shrink in the face of complexity and ambiguity we all live with every day. APA did develop a definition of evidence-based practice that included some recognition of the limitations of laboratory conceptualizations in its proposed requirement that clinical judgment be considered an essential third of the process. The PTSD guidelines ignoring of this supposed directive feels, once again, like an unfortunately consistent retreat to our more widely accepted medical peers approach to physiology-based problems- for which they benefit from a far better match between subject and method.	Thank you for your comment. Clinical practice guidelines (CPGs) are a piece of evidence-based practice in psychology, but not the whole thing. Rather, they are intended to inform the best available evidence component to be considered together with clinician expertise and patients' values, preferences, and individual characteristics.

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		I would implore those voting on the guidelines to stand for the uniqueness of the special intellectual challenge of psychology and to avoid the unnecessary black-and-white thinking of objective and subjective. Understanding mind and its treatment demands that we take a special place among the sciences and impress with our courage rather than retreat and follow.	
Christopher Nguyen (Group: SHARP)	General Comment	Suggested comments for submission to the portal: Commentary on APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults - 2024 Update -- Anica Pless Kaiser, PhD, Eve H. Davison, PhD, Jennifer Moye, PhD, ABPP, Jennifer Schuster Wachen, PhD & Avron Spiro, PhD, on behalf of the Stress, Health, and Aging Research Program (SHARP) at VA Boston Healthcare System [PASTED COMMENTS FROM ANICA PLESS KAISER (Group: SHARP at VA Boston Healthcare System)].	Thank you for your review and feedback. Please refer to the panel's response to comments submitted by Anica Pless Kaiser (Group: The Stress Health and Aging Research Program [SHARP] at VA Boston Healthcare System) above. Please also refer to the pharmacological treatment section for a response to comment point #4.
Christopher Nguyen (Group: Committee on Aging [CONA])	General Comment	The guideline currently lacks sufficient consideration of lifespan developmental influences on the presentation, assessment, and treatment of PTSD, particularly regarding the unique needs of older adults. Including content to/and references from the following is highly recommended: American Psychological Association (2024). Guidelines for Psychological Practice With Older Adults. Retrieved from https://www.apa.org/practice/guidelines/older-adults.pdf Hinrichsen, G. A., & Emery-Tiburcio, E. E. (2022). Introduction to special issue: Foundational knowledge competencies in	Thank you for your comment. Treatments and outcomes were determined by the Clinical Practice Guideline methodology. The panel included additional information on select demographics that were reported within the 368 individual studies across the fifteen systematic reviews / meta-analyses, and this can be found in Appendix H of the guideline. Of the 368 unique studies that were identified across the fifteen systematic reviews / meta-analyses, 3 of them reported including participants aged 65 and older. The panel was limited to the data that was presented across

Commenter (Group or Individual?)	Section	Comment	Panel Response
		geropsychology. Clinical Psychology: Science and Practice, 29(1), 1-3. https://doi.org/10.1037/cps0000066 Jacobs, M. L., & Bamonti, P. M. (2022). Clinical practice: A foundational geropsychology knowledge competency. Clinical Psychology: Science and Practice, 29(1), 28-42. https://doi.org/10.1037/cps0000046 Mast, B. T., Fiske, A., & Lichtenberg, P. A. (2022). Assessment: A foundational geropsychology knowledge competency. Clinical Psychology: Science and Practice, 29(1), 43-58. https://doi.org/10.1037/cps0000055 Pless Kaiser, A., Cook, J. M., Glick, D. M., & Moye, J. (2019). Posttraumatic stress disorder in older adults: A conceptual review. Clinical gerontologist, 42(4), 359-376. Rutherford, B. R., Zilcha-Mano, S., Chrisanthopolous, M., Salzman, C., Zhu, C., Cimino, N., ... & Roose, S. P. (2021). Symptom profiles and treatment status of older adults with chronic post-traumatic stress disorder. International Journal of Geriatric Psychiatry, 36(8), 1216-1222. Woodhead, E. L., & Yochim, B. (2022). Adult development and aging: A foundational geropsychology knowledge competency. Clinical Psychology: Science and Practice, 29(1), 16-27. https://doi.org/10.1037/cps0000048	the reviews and encourages the development of future reviews that focus on this important population.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Kelly A O'Malley, Jennifer L Sullivan, Whitney Mills, Jane Driver, Jennifer Moye, Trauma-Informed Care in Long-Term Care Settings: From Policy to Practice, The Gerontologist, Volume 63, Issue 5, June 2023, Pages 803-811, https://doi.org/10.1093/geront/gnac072	
Gabe Twose (Group: APA Committee for Global Psychology [CGP])	General Comment	APA's Committee for Global Psychology (CGP) wishes to share appreciation to our colleagues for your far reaching work on this comprehensive Clinical Practice Guidelines for the Treatment of PTSD in Adults. From an international perspective, a strong commitment in the paper to context sensitivity, and specially 'Cultural humility and diversity competence' is much appreciated. Likewise it is good to see the use of international references to help develop a comprehensive view of how this important topic is approached across different regions. CGP particularly appreciate the consideration, during the scoping stage, to whether or not to consider C-PTSD given that this is contained within ICD-11, but not within DSM-5. The rationale given that 'the updated guideline would better address the interests of an international audience regarding effective treatments' shows a very welcome attunement to the needs of the different audiences who will make use of this work.	Thank you for your feedback. The panel is adding a statement to the document on the international applicability per your suggestion.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		It is also good to see acknowledgement to other approaches to working with PTSD, such the involvement of respected healers in the community. In terms of any room for improvement, it might be useful to specify what the authors believe is the international applicability of the conclusions of this paper. On one hand the work makes great efforts to acknowledge context as described above. On the other hand welcome limitation are noted—for example that 'increased international representation of studies is needed as the majority of the studies identified within the systematic reviews and meta-analyses were conducted in North America' (ref lines 2215-2217). It should be made clear that it is not necessarily expected that the scope of this work should include, or aim to speak to, those from all regions. However building on the principles of context-sensitivity it may be helpful for the reader to understand whether the authors intend for this work to be focused in a US context or whether it is sufficiently well-informed to be considered as an internationally applicable guidance document. Thank you again for your hard work. Other than the above points of feedback, CGP are happy to support these Guidelines.	
Christine A. Courtois, Ph.D.,	Implementation Considerations	As noted above, the commentary in this guideline is greatly expanded from the 2017 document, for which I commend this	Thank you for your kind review and feedback. The panel added additional information to the

Commenter (Group or Individual?)	Section	Comment	Panel Response
ABPP (Individual)		panel. Below, I list additional issues for the panel's consideration for inclusion in the final document. • the need for training of the clinician is mentioned a number of times. I suggest that the panel make an overall recommendation emphasizing the need for routine inclusion of information about trauma and approaches to trauma treatment and research in the general curriculum for psychologists, rather than only mentioning the requirement for continuing education or training and expertise in only a specific evidence-base treatment or methodology. At the present time, this type of training is largely unavailable despite the ubiquity of trauma and its consequences in the general population and in clinical practice (See Courtois & Gold, 2009). A call from this panel for trauma to be included in the curriculum and updated during the course of licensure would hopefully influence training directors and administrators of clinical and research training programs and state Boards of Psychology. Moreover, the panel could recommend different levels and depth of training and expertise as needed by the clinician or researcher, as outlined in the APA/Division 56 document on competencies in the treatment of trauma (Cook & Newman). In my view, stand-alone CE courses are insufficient and much more background and depth of information is needed as is found in multi-session certificate training programs (that include supervision/consultation).	implementation considerations recommendation to this point.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Christine A. Courtois, Ph.D., ABPP (Individual)	Treatment Recommendations	• there is little, if any, mention of Emotionally Focused Therapy in the document, despite the fact that there is considerable evidence as to its efficacy, in general and as pertains to trauma and complex trauma. This may have been missed due to the breath of the scoping questions. See books by Paivio & Pascuale Leone for the original treatment formulation and Paivio & Angus for EFT plus NET approaches. These should be mentioned and the evidence base noted. This is one of the affect based approaches that is missing.	Thank you for your comment. Treatments and outcomes were determined by the Clinical Practice Guideline methodology. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria.
Christine A. Courtois, Ph.D., ABPP (Individual)	Treatment Recommendations	• Relational psychodynamic psychotherapy is inadequately recognized. Research based on the significance of the relationship and the need for depth therapy by some traumatized individuals (especially for the complex/multiply/developmentally traumatized and those with significant moral injuries and repeated victimization by intimates). Short-term PTSD symptom-focused treatment is not the answer for everyone and, although this is mentioned throughout the document, I'd suggest giving it more emphasis.	Treatments and outcomes were determined by the Clinical Practice Guideline methodology. Given the interest in and widespread use of psychodynamic therapies, the CPG update panel worked extra hard to look into this. Upon initial review, the panel found that there was insufficient literature that met the IOM criteria. The panel went above-and beyond the traditional CPG methods by engaging in several rounds of updated literature searches - explicitly for more literature on psychodynamic psychotherapies. Unfortunately, in spite of these significant efforts, the panel found that there was still insufficient literature that met the IOM criteria to be able to make a

Commenter (Group or Individual?)	Section	Comment	Panel Response
			recommendation regarding psychodynamic approaches and other commonly used interventions/ approaches.
Christine A. Courtois, Ph.D., ABPP (Individual)	Recommendations for Research	• a call for more funding for treatments that have not been developed in academic settings. This is an automatic bias due to the differences in resources and personnel to development of a data base. This suggestion also pertains to community settings where research may not be easily established or supported.	Thank you for your suggestion. The panel is adding information on this to the document.
Christine A. Courtois, Ph.D., ABPP (Individual)	General Comment	• replace the term "simple" PTSD with either "conventional" or "traditional" or some other more neutral descriptor in recognition that there is nothing simple about PTSD as emphasized correctly throughout this document. It is unfortunate that the term was originally coined as it may have contributed to defensiveness and misunderstanding of the term "complex" trauma/PTSD, making one seem to be of lesser significance than the other. I would urge making this point in the document.	Thank you for your comment. The panel worked to address this in the document while still acknowledging that "simple," referring to ICD-11 PTSD, is still used in clinical practice.
Christine A. Courtois, Ph.D., ABPP (Individual)	General Comment	• incorporate additional information from the recent Professional Practice Guidelines for PTSD and the ones for CPTSD, in recognition of the three prong definition of evidence-based practice and the practical utility of consensus clinician and researcher recommendations. Begin to integrate the two so that they seem less mutually exclusive.	Thank you for your comment and please see additional responses to your comments below. The panel included references to both these new guidelines in the updated CPG as well as discussion of broader evidence-based practice. Further, decision aids are developed for each finalized CPG, and one will be developed for this CPG that will include links to both those PPGs to better integrate

Commenter (Group or Individual?)	Section	Comment	Panel Response
			all the guidelines and more as part of evidence-based practice.
Christine A. Courtois, Ph.D., ABPP (Individual)	General Comment	• there is a lack of attention to dissociation throughout this document. Dissociation has considerable research as a rather common posttraumatic response that ranges dramatically due to severity of trauma, developmental, and relational/attachment issues. I suggest a brief section on dissociation (with mention that is it is not the focus of this guideline) but that its significance of a mediator and moderator of treatment outcome needs ongoing investigation. Also, there are cultural dimensions of dissociation and dissociative symptomatology that deserve mention in the document. There is also a need to emphasis the lack of available education regarding dissociation in the professional curriculum and that it is easily missed by the uninformed. Calling for more research and education are warranted. Additionally, there is no mention of standard screening for dissociation as part of a standardized assessment, something that some experts in dissociation have called for, again because dissociation is easily missed and can be very relevant in terms of treatment outcome. Much more research is needed on this latter point of course.	Thank you for your comment. Treatments and outcomes were determined by the Clinical Practice Guideline methodology.
Christine A. Courtois, Ph.D., ABPP (Individual)	Implementation Considerations	• make one or more recommendations regarding prevention and social or collective intervention efforts in the population. Recognize that treatment of the individual is but one approach and more education about trauma and attempts at the societal level to address it are in desperate need.	Thank you for your comment this is outside the purview of the Panel's work as the guideline does not address prevention of PTSD.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Christine A. Courtois, Ph.D., ABPP (Individual)	General Comment	• I was pleased to see attention to comparison with the findings of other CPGs for PTSD. Reduction in PTSD symptom severity as a primary outcome is part of all of them and this panel is to be commended in recognizing that other symptoms and their outcomes, as found in CPTSD, should also be included.	Thank you for your feedback.
Christine A. Courtois, Ph.D., ABPP (Individual)	General Comment	• the definition and scope of treatments seemed over-attenuated to me, although this version was much more broad-based than its 2017 predecessor. I suggest continuing to emphasize that a wide variety of techniques/orientations remain to be developed and researched.	Thank you for your feedback. The initial PICOTS list was aspirational but if an intervention was not listed in the Interventions category it was still considered if it appeared in the research identified within the systematic reviews. This point is noted in the guideline document.
Christine A. Courtois, Ph.D., ABPP (Individual)	Recommendations for Research	• Many of the recommendations for research are a repeat of those in the original document (such as harms and burdens reporting, adverse reactions, dropouts or concluders), and remain warranted as they are still inadequately incorporated. Continued development of a template for research that lists all of these dimensions is needed. I hope these comments and suggestions are useful to the finalizing of the document. With appreciation of all of the effort that goes into producing a guideline such as this one.	Thank you again for taking the time to provide this helpful feedback.
Jessica Hamblen (Individual)	General Comment	I encourage the committee to think about the organization and structure of the guideline. Very little attention is given to providing a justification for the recommendations. There are only a few sentences in a table to provide support for the decisions that were made. Appendix J has additional	Thank you for your comments. At this time, the APA guideline development process follows the IOM's (2011 a, b) standards as well as follow some modified GRADE guidance. We included notes about these in the following subsections within the

Commenter (Group or Individual?)	Section	Comment	Panel Response
		information, but it is not in an easy to use format. From the comments that have been included so far in response to the guideline, it is clear that people believe these recommendation decisions are personal or arbitrary even. Instead there is an a priori methodology to how recommendations are made. I think it is important to spend more time up front reviewing that methodology and then provided greater justification for those recommendations. Related to the point above, the more you can follow best practices, the more defensible the decisions you come to. The committee seemed to mostly follow GRADE but then (I believe) in a few places did not. I would encourage the committee to just use GRADE. But if they are not going to, then explain when and why you deviated.	Processes and Methods for the CPG section: Decisions Regarding Assessment of Inclusion/Exclusion Criteria, Assessing Strength of Evidence, and Development and Use of Grid. While we provide a summary of rationale with each recommendation, to make it more readable and user friendly we include further details in the "Grid" in the supplemental materials. We will consider for future guidelines if there are ways to make this more user friendly as well.
Jessica Hamblen (Individual)	General Comment	It appears as if reduction in PTSD symptoms could be self report or clinician rated. I would argue clinician rated is a less biased measure. However, in any case, you should specific that it included both.	Thank you for your comment. When drafting recommendations, the panel gave stronger weight to masked interviewer rated PTSD ratings over self-report ratings.
Jessica Hamblen (Individual)	General Comment	I am the developer of the PTSD Repository. I know it is confusing, but it is not quite accurate to call it the AHRQ's PTSD Repository. AHRQ did abstract the data and you could cite their annual PTSD reports and call it the AHRQ annual update (and link to the AHRQ website). Or if you pulled the data from the PTSD Repository you could call it the National Center for PTSD's PTSD Repository. Even more confusing is that the National Center for PTSD worked with Pim Cuijpers to create a dataset of just psychotherapy vs controls that sits on the metapsy website. But it is really all the same data. That	Thank you very much for this clarification. We will correct this as we finalize the document.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		said, I understand wanting to give Pim (and therefore metapsy) credit for the work they did. I am happy to work with you on the wording if that is helpful.	
Jessica Hamblen (Individual)	Treatment Recommendations	"The decision to include TFCBT as a group of treatments that are recommended is understandable but confusing. Why list specific names and then also the group of treatments. Do you really mean that every treatment that could be categorized as TFCBT is a recommended first line treatment. I know you provide a definition of TFCBT in a footnote, but I think it requires more than a foot note. In addition, the definition does not even say that the elements need to be primary or that trauma processing is required. As written, psychoeducation could qualify and maybe coping interventions generally depending on how you interpret "rauma focused coping." And just to say it again, the rationale provided in the table is really insufficient and fails to explain to readers where the recommendation comes from.	Thank you for your comment. The panel struggled with categorizing the interventions as the systematic review that was used as the primary empirical basis lumped the interventions into one (i.e., CBT-mixed interventions).
Jessica Hamblen (Individual)	General Comment	Did committee look at cannabis?	Thank you for your comment. Though the systematic reviews did not identify cannabis interventions, a comment was added in the Recommendations for Research section noting that more research is needed on cannabis interventions for the treatment of PTSD.
Jessica Hamblen (Individual)	General Comment	Should hypnosis be listed under psychotherapy? I would put as CIH."	The review conducted by the Agency for Healthcare Research and Quality that served as the primary empirical basis categorized hypnosis under "psychological interventions" and excluded "complementary and alternative medicine

Commenter (Group or Individual?)	Section	Comment	Panel Response
			approaches" (Hoffman et al., 2018). The panel followed the categorization used by review authors.
Ritu Kapur (Group: American Psychological Association of Graduate Students [APAGS])	General Comment	The American Psychological Association of Graduate Students (APAGS) Committee is pleased to provide the following comment to the Proposed Clinical Practice Guidelines for the Treatment of PTSD in Adults. We hope that our comments will be helpful for revisions to the proposed guidelines. We are able to support the passage of the proposed guidelines in their current form and suggest consideration of the following edits outlined in the detailed comments section.	Thank you for your review and critical feedback. The comments and responses to your comments are organized into the respective categories below.
Ritu Kapur (Group: APAGS)	General Comment	Line 249: "The Panel considered four factors as it drafted recommendations based on IOM standards (2011a): 1) overall strength of the efficacy evidence; 2) the balance of benefits vs. harms/burdens; 3) patient values and preferences; and 4) applicability breadth or limitations." Expand on how each factor was weighed in practice. For example, explain how patient values were gathered or considered in forming recommendations.	Thank you for your comment. One community member (Anthony Sgherza) was on the panel that provided important input on patient/community member experience in receiving treatments for PTSD. Clinician members were also asked to provide input from their experience with patients. Diverse research literature was also referred to for this factor and cited as the panel reviewed the evidence and drafted recommendation statements. Please see the section "Development and Use of Grid" of the guideline for information on these four factors. Further details of Documentation of the panel's decision-making process can be found in Appendix J (Grid).
Ritu Kapur (Group: APAGS)	General Comment	Line 260: "The APA guideline is the first update of the previous 2017 guideline for the treatment of PTSD in adults."	Thank you for your comment. We agree it is somewhat redundant however in this case we

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		This sentence is somewhat redundant since it has already been mentioned that this is an update. Streamline by removing redundancy. For example: "This guideline updates APA's 2017 recommendations for PTSD treatment in adults."	wanted to emphasize that it was the first update (clarifying there were no previous updates).
Ritu Kapur (Group: APAGS)	General Comment	Line 265: "The first type of recommendations is implementation considerations..." The list following this sentence lacks parallel structure. Ensure consistency in phrasing. For example: Considerations for what patients need to know about informed consent The role of provider and patient factors in PTSD treatment Barriers to treatment engagement and monitoring response to treatment	Thank you for your comment. In this case we wanted to convey content in specific ways. But we will keep this suggestion in mind for future content clarity.
Ritu Kapur (Group: APAGS)	Treatment Recommendations	Line 323: "First-Line For patients with PTSD, the Panel recommends offering the following psychological interventions over no intervention or treatment as usual (TAU): Cognitive Processing Therapy (CPT), Prolonged Exposure (PE), Trauma-Focused Cognitive Behavioral Therapy (CBT)." The term "Trauma-Focused Cognitive Behavioral Therapy (CBT)" may be too broad without further clarification. Include a footnote or brief explanation that trauma-focused CBT encompasses various techniques like psychoeducation, cognitive restructuring, and exposure therapy.	Thank you for your comment. A footnote was inserted below the "Treatment Recommendations – Psychological Interventions" table: "Trauma-focused CBT refers to a broad grouping of therapies and not a specific therapy that include elements such as psychoeducation, cognitive restructuring, in vivo exposure, imaginal exposure, or trauma-focused coping and not a specific therapy."
Ritu Kapur (Group: APAGS)	Treatment Recommendations	Line 329: "...the degree of benefit to harm/burden strongly favors these interventions over waitlist or TAU." The phrase "degree of benefit to harm/burden" could be clearer. Rephrase for clarity. For example: "...the benefits	Thank you for your comment.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		significantly outweigh the harms or burdens when compared to waitlist or TAU."	
Ritu Kapur (Group: APAGS)	Treatment Recommendations	Line 336: "...there are multiple studies with varying methodological quality showing moderate to large effects..." The phrase “varying methodological quality” could benefit from more specificity. Clarify what aspects of methodology are variable (e.g., sample size, study design). This would help readers understand potential limitations better.	Thank you for your comment. This section of the table is intended to provide a brief summary with further details included in the “grid’ included in the supplemental materials.
Ritu Kapur (Group: APAGS)	Treatment Recommendations	Line 355: "...there is insufficient evidence for the Panel to recommend for or against..." This phrase has been used frequently throughout the document without much variation. Consider rephrasing some instances for variety. For example: "The available data does not support making a recommendation either way."	We agree that it is typically good to have more variation in phrasing a document. In this particular case however, and consistent with best practices (e.g. IOM standards), it is important to use consistent phrasing when describing the panel’s recommendations and the evidence to provide clarity and consistency to readers.
Ritu Kapur (Group: APAGS)	General Comment	Page 33-34 Section: Definition of the Problem Line 543: Suggest incorporating examples of types of traumatic events to the sentence. Suggest revising to “... individuals who have had exposure to a traumatic event event (i.e. actual or threatened death, serious injury, or sexual violence)”.	Thank you for your comment. Additional examples were incorporated in the final document.
Ritu Kapur (Group: APAGS)	General Comment	Line 546: Consider adding statistics on how widespread and global of a concern PTSD is if this is a sentence that will remain.	Thank you for your comment. Information on lifetime prevalence of trauma exposure is included in the Background section within the Executive Summary.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Ritu Kapur (Group: APAGS)	General Comment	Line 548-551: Consider rewording this sentence and adding additional sources on the diagnostic challenges to PTSD diagnosis as this does not accurately reflect the true challenge to PTSD misdiagnosis or under diagnostic issues. Consider revising to " Diagnostic challenges due to a variety of factors such as symptom overlap with other disorders, variable symptom onset, cultural factors impacting symptom presentation, subclinical presentation, overall barriers to treatment and inequities in care are all associated with PTSD impacting overall clinical presentation and therefore may lead to underdiagnosis or misdiagnosis of PTSD."	Thank you for your comment. The panel discusses these important issues within the document in the implementation considerations sections as well as throughout the discussion section.
Ritu Kapur (Group: APAGS)	General Comment	Line 568: Citation is missing parenthesis, Revise to : ...substance abuse (American Psychiatric Association, 2022).	Thank you for noting this. It has been corrected in the final copyedit of the guideline.
Ritu Kapur (Group: APAGS)	General Comment	Page 44 Section: Vetting and Appointment of Members to the Gup Line 805-810: There is a formatting error on these lines. Lines are indented.	Thank you for your comment. This was indented due to it being a quote. However, it will be adjusted, and quotes will be added for the final copyediting of the guideline.
Ritu Kapur (Group: APAGS)	General Comment	Page 67 Line 1296: The following sentence, "Adult person of color identities may affect treatment-seeking behavior, treatment choice, engagement and outcomes." does not accurately reflect language accepted in the field of psychology more broadly. Consider revising to "Adults who identify as part of the BIPOC community may vary in their style of treatment-seeking behavior, treatment choice, and engagement with treatment for PTSD." This better aligns with the push towards person-first language.	Thank you for the suggestion. We use the term Person of Color instead of BIPOC to be consistent with APA's (2023) *Inclusive Language Guide*.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Ritu Kapur (Group: APAGS)	General Comment	Line 1301: There is a typo or words missing here, "...preferences and needs incorporating these into care contribute to favorable outcomes." Please revise.	Thank you for noting this. This edit was made by including the word "and" between "needs" and "incorporating."
Ritu Kapur (Group: APAGS)	General Comment	Line 1302: Consider changing "Patient characteristics," to "Individual differences among patients."	Thank you for your comment. We are striving to use consistent language saying patient characteristics.
Ritu Kapur (Group: APAGS)	General Comment	Line 1307-1312: Consider incorporating this single sentence into one of the previous paragraphs.	Thank you for your comment. This sentence appears intentionally as a separate paragraph so it would stand out more than if it were embedded within the previous paragraphs.
Ritu Kapur (Group: APAGS)	General Comment	Page 68 Section: Barriers to Treatment Consider utilizing sub-headings within this section to more clearly outline each specified barrier to treatment.	Thank you for this suggestion. Because many of the sub-areas intersect and overlap with each other in various ways we have chosen to keep this as one section instead of splitting into multiple sections.
Ritu Kapur (Group: APAGS)	General Comment	Page 72 Section: Treatment Engagement Consider incorporating consideration for treatment engagement by setting (i.e., VA vs. Community health centers); McClendon, J., Dean, K. E., & Galovski, T. (2020). Addressing diversity in PTSD treatment: Disparities in treatment engagement and outcome among patients of color. Current Treatment Options in Psychiatry, 7, 275-290. Hundt, N. E., Helm, A., Smith, T. L., Lamkin, J., Cully, J. A., & Stanley, M. A. (2018). Failure to engage: A qualitative study of veterans who decline evidence-based psychotherapies for PTSD. Psychological services, 15(4), 536.	Thank you for this suggestion. We will suggest attention to this issue on the website of this guideline and consider this for future updates of this guideline.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Mott, J. M., Stanley, M. A., Street Jr, R. L., Grady, R. H., & Teng, E. J. (2014). Increasing engagement in evidence-based PTSD treatment through shared decision-making: A pilot study. Military Medicine, 179(2), 143-149.	
Ritu Kapur (Group: APAGS)	General Comment	Page 74 Line 1490-1491: "The concept of Culture culture and diversity competence" Section: Professional Competence Consider whether "Culture and diversity competence," (a phrase repeated throughout this section), is the correct term. Consider revising "cultural competence."	We prefer to also include the word diversity because we are referring to more than just culture here. Using the word diversity helps make this more inclusive.
Ritu Kapur (Group: APAGS)	General Comment	Page 76 Line 1520-1521: Consider revising, "...it is important that researchers aspire to explore culture and diversity's impact on treatment delivery and effectiveness (Heim et al., 2022)." to "...it is important that researchers aspire to explore the relationship between cultural identity and treatment delivery and effectiveness…"	We prefer to also include the word "diversity" because we are referring to more than just culture here. Using the word "diversity" helps make this more inclusive.
Ritu Kapur (Group: APAGS)	Future Research Needs	Page 99: Section: Future Research Needs, Consider incorporating EDI considerations throughout various subsections (e.i., include EDI considerations within Harms and Brudens Reporting, Assessing & Defining Outcomes, etc.), in addition to the specific section outlining specific EDI-focused research directions	Thank you for this comment. EDI is very important, and we strove to highlight this throughout multiple sections throughout the document. We chose though to have each sub-section focus more narrowly on a specific topic to better focus the reader on that particular area.
Sue Hobbs (Group: Children,	General Comment	The authors note that practice guidelines are needed for treating PTSD in children. We strongly agree. Do you know if this is being done? On the practice guidelines page (https://www.apa.org/practice/guidelines) please keep the	APA is not currently developing a clinical practice guideline for treating PTSD in children. Future topics are to be determined. However, we will

Commenter (Group or Individual?)	Section	Comment	Panel Response
Youth, and Families [CYF])		links to National Traumatic Stress Network and SAMHSA up when the existing policy is replaced, so that practitioners have some information to supported by APA.	definitely continue to provide these relevant resources.

Section 1-A: Response to Comments from Psychotherapy Action Network (PsiAN)

Commenter (Group or Individual?)	Section	Comment	Panel Response
Linda Michaels (Group: Psychotherapy Action Network [PsiAN])	General Comment	Psychotherapy Action Network offers comments to the American Psychological Association in response to its update of the APA Clinical Practice Guideline for the Treatment of PTSD. Psychotherapy Action Network (PsiAN) advocates for accessible, affordable, effective, and ethical psychotherapies that create meaningful change for anyone who wants or needs them. PsiAN is a nonprofit organization with 6,000 individual members and 90 organizational partners. When the original American Psychological Associations (APA) PTSD clinical practice guidelines were published, PsiAN expressed extensive concerns that were endorsed by nearly 60,000 signatories of a petition. We have significant concerns about this proposed update to the 2017 guidelines. Our concerns fall into four main categories, with additional detail outlined below: 1. Problems arise from an over-reliance on systematic reviews and meta-data. 2. Over-emphasis on exposure-based therapies results in significant limitations. 3. The misrepresentations of the Institute of Medicine (now the National Academy of Medicine) framework and of APA's own definition of evidence-based treatment are a major weakness. 4. Questions remain about the applicability of research studies to community practice.	Thank you for your review and critical feedback. The comments and responses to your comments are organized into the respective categories below. Response to #1. Approach and data selection, can be found in Section 1-B: Overreliance on Systematic Reviews / Meta-Analyses.
Linda Michaels (Group: PsiAN)	General Comment	**2. Over-emphasis on exposure-based therapies and a near-total eclipse of clinical interventions focused on addressing**	Thank you for your comment. Given the interest in and widespread use of psychodynamic therapies, the CPG update

Commenter (Group or Individual?)	Section	Comment	Panel Response
		sensitivity in the clinical situation and the importance of the therapeutic alliance The APA's approach over-focuses on exposure therapies in part as an artifact of the proportion of studies done on them. This is highly problematic: it elides the serious problems of exposure treatment uptake among people with PTSD. Meta-data undercounts treatment dropout, which is exceedingly high for exposure-based treatments, and while some people do better with exposure therapies, even "responders" often retain their diagnosis and may be highly symptomatic. While exposure-based therapies have been assessed by a large number of studies and have been widely disseminated (in the VA system, for example), they have failed to address the needs of patients who suffer from highly symptomatic developmental trauma and those presenting with more complex PTSD symptomatology. The criteria used by the guideline authors leads to an overemphasis on exposure-based psychotherapies which encourage patients to recount and re-experience painful aspects of their traumatic experiences. For clinical practice guidelines to be useful in helping people and reducing suffering, this crucial problem must be acknowledged. Newer research studies on non-exposure-based treatments, or affect-focused treatments, have been completed recently and others are in the publication loop or underway presently. Affect-focused treatments aim to reduce traumatic stress symptoms without directly targeting the trauma memory or related thoughts, and they focus on the emotional and interpersonal consequences of the trauma. These non-exposure-based therapies have the potential to provide patients with skills and confidence to improve social interactions,	panel worked extra hard to look into this. Upon initial review, the panel found that there was insufficient literature that met the IOM criteria. The panel went above-and beyond the traditional CPG methods by engaging in several rounds of updated literature searches - explicitly for more literature on psychodynamic psychotherapies. Unfortunately, in spite of these significant efforts, the panel found that there was still insufficient literature that met the IOM criteria to be able to make a recommendation regarding psychodynamic approaches and other commonly used interventions/ approaches. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		gain social support, and then – without therapist encouragement – expose themselves to trauma reminders outside of the therapy context. Studies of these treatments show they are highly effective with less treatment dropout than exposure-based treatments, and they should be included in this guideline. (See Markowitz, 2024; Markowitz etal 2015; Shea etal 2023; Keefe etal 2024; which are listed below in the References.) Psychodynamic psychotherapy is highly sensitive to the patient's tolerance of addressing trauma directly thus averting disruptions of treatment that can occur via an overly aggressive exposure protocol. While psychoanalytic psychotherapies have sometimes been described as "non-trauma focused," they are, in fact, highly focused not only on re-telling of actual experiences, but also on profound reflections on the affects, meanings, and multiple impacts of those experiences as expressed in symptoms, relationships, and basic assumptions. Indeed, psychodynamic psychotherapy is a widely used treatment which builds upon over 120 years of clinical writings and practice involving the impact and treatment of trauma and associated disorders. This treatment approach is valuable in addressing problems in the therapeutic alliance, including those that arise from the shame and mistrust common among trauma survivors. In addition, it is essential in addressing transference factors, such as anger and fear involving the therapist, that stem from early childhood adversity or subsequent trauma, and may disrupt treatment. Psychodynamic interventions addressing disruptions in the therapeutic alliance can be of value in any form of psychotherapeutic treatment. Furthermore, psychodynamic psychotherapy works to identify and address internal conflicts and defenses about angry and dependent feelings and fantasies and	Further discussion of this and the broader issue is included on pages 30, 45-48, and 103, of the guideline document.

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		wishes for closeness that are common following severe trauma. Focusing on these factors is a unique aspect of this treatment. While research involving psychodynamic psychotherapy has been limited owing to a variety of factors, a recently developed trauma-focused psychodynamic psychotherapy (Busch et al., 2021) manualized treatment has recently made it possible to conduct research which demonstrates promise in clinical studies of PTSD with Veteran (Busch and Milrod, 2018; Busch et al., 2019) and LGBTQ (Keefe et al, 2023) populations. It provides a symptom focused approach that may be more effective than a more traditional psychodynamic psychotherapy which addresses problems more generally. In addition, this treatment helps patients to develop skills and self-understanding in an effort to diminish the likelihood of recurrence of symptoms. **References** Busch, F. N., Milrod, B. L., Chen, C., & Singer, M. (2021). Trauma focused psychodynamic psychotherapy. Oxford University Press. Busch FN, Milrod BL (2018). Trauma focused psychodynamic psychotherapy. Psychiatric Clinics of North America. 41: 277-287. Markowitz, J. C. (2024). Interpersonal psychotherapy for posttraumatic stress disorder: A critical review of the evidence. *Journal of Clinical Psychiatry, 85*(2), Article 23nr15172. Busch FN, Nehrig N, Milrod B (2019). Trauma-focused psychodynamic psychotherapy of a patient With PTSD in a Veterans Affairs setting. American Journal of Psychotherapy, 72: 24-28	

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		Keefe, J. R., et al. (2023). Open trial of trauma-focused psychodynamic psychotherapy for posttraumatic stress disorder among LGBTQ individuals. *American Journal of Psychotherapy, 76*, 115–123. Keefe, J. R., Kimmel, D., & Weitz, E. (2024). A meta-analysis of interpersonal and psychodynamic psychotherapies for posttraumatic stress disorder. American Journal of Psychotherapy, 77(3), 119–128. https://doi.org/10.1176/appi.psychotherapy.20230043 Markowitz, J. C., Petkova, E., Neria, Y., Van Meter, P. E., Zhao, Y., Hembree, E., Lovell, K., Biyanova, T., & Marshall, R. D. (2015). Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. *American Journal of Psychiatry, 172*(5), 430–440. https://doi.org/10.1176/appi.ajp.2014.14070908 Shea, M. T., Krupnick, J. L., Sautter, F. J., Mete, M., Green, B. L., Norman, S. B., Finley, S. L., & Eaton, E. (2023). A randomized clinical trial comparing interpersonal psychotherapy with prolonged exposure for the treatment of PTSD in veterans. *Journal of Anxiety Disorders, 99*, Article 102770. https://doi.org/10.1016/j.janxdis.2023.102770	
Linda Michaels (Group: PsiAN)	General Comment	**3. The IOM and APA guidelines regarding evidence** We question how the Institute of Medicine (IOM) guidelines are being interpreted by the framers of the proposed revision. The IOM clearly states that clinical and research findings should be	Thank you for your comment. In selecting the quality existing and updated 15 systematic reviews/meta-analyses used by the panel, the goal was not to operate in

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		integrated when developing clinical practice guidelines, encourages the inclusion of treatments with extensive clinical evidence, and warns against an "isolationist" approach that excludes either approach. The IOM states clearly that, while some authorities including the National Institutes of Health Consensus Development Conference, have recommended that those who develop systematic reviews and those who then base guidelines upon those reviews should operate in "complete isolation" of one another "to discourage the clinical experts from biasing the SR results" (Kudler, 2019, p. 93), the IOM authors reject this strategy: The [IOM] committee is critical of the isolationist approach because it inhibits knowledge exchange between clinical content experts and methodologists, potentially degrading their abilities to appreciate the nuances of evidence and clinical questions pertinent to the formulation of recommendations. (p. 96) The APA's own definition of evidence-based practice, which recognizes research, clinical judgment, and patient preference as equally important, is aligned with an accurate reading of the IOM, and should be respected when defining the evidence base for a practice guideline. The proposed PTSD guideline relies on research findings – and a limited set at that – and fails to integrate data from the latter two components by which APA itself defines evidence-based practice. In summary, APA's proposed Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 falls below IOM's standard and APA's own Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. If science is an effort to accurately describe natural phenomena, then any scientific approach to the treatment of PTSD needs to address the realities of clinical practice.	"complete isolation" between the panel and the systematic reviewers. Rather, this approach was taken in order to Avoid potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between the guideline developers and groups conducting the systematic reviews. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. At any time, the panel members wished, they were welcome to examine the individual studies contained within a particular review. The panel members frequently did this when reviewing the Grid. To save panel member time, APA staff were also available to ask any clarification or follow-up questions from panel members to the authors of the reviews. Clinical practice guidelines (CPGs) are a piece of evidence-based practice in psychology, but not the whole thing. Rather, they are

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		References American Psychological Association. (2006). Evidence-based practice in psychology. American Psychologist, 61(4), 271–285. https://doi.org/10.1037/0003066X.61.4.271 American Psychological Association. (2021). Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. Retrieved from https://www.apa.org/about/policy/evidence-based-psychological-practice-health-care.pdf. American Psychiatric Association. (2024). APA's Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update. Frequently Asked Questions. Institute of Medicine. (2011). Clinical practice guidelines we can trust. Washington, DC: The National Academies Press. Kudler H. (2019). Clinical practice guidelines for posttraumatic stress disorder: Are they still clinical?. Psychotherapy (Chicago, Ill.), 56(3), 383–390. https://doi.org/10.1037/pst0000236	intended to inform the best available evidence component to be considered together with clinician expertise and patients' values, preferences, and individual characteristics. The panel strove to clarify this point in the Intended Use of the Guideline, Evidence-Based Practice in Psychology, and Conclusion sections of the document and will add some additional emphasis on this to further highlight.
Linda Michaels (Group: PsiAN)	General Comment	**4. Questions about the applicability of research studies to community practice** The proposed guideline implies that the results of research studies used to make treatment recommendations can be immediately translated into the clinical practice of most mental health professionals. Randomized controlled trials, however, may not accurately reflect either the patient populations or the treatment	Thank you for your comment. The panel wanted to ensure applicability of the recommendations as well and so worked to address this in several ways. The panel took care to provide detailed information on the included population for each included review in the Diversity of Samples Included in

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		approaches used in the community. Additionally, significant questions remain about how to best approach comorbidity which is more the rule than the exception among those with PTSD. Finally, many patients have only a partial response to the treatments that are recommended, and significant questions remain about long term outcome. In summary, the guideline as it stands currently is riddled with problems concerning the nature of evidence used in making recommendations, the current state of knowledge about long-term outcome, and the applicability of research studies to community practice. The approach taken in developing this guideline predetermined the exclusion of psychodynamic psychotherapy, thus undercutting the use of a valuable and widely utilized clinical approach to PTSD. This may in turn, albeit inadvertently, empower groups such as health insurance companies to limit or ration effective care to advance their financial gain. It also may limit future research on and training for psychodynamic psychotherapy. Therefore, the guideline presents an unfortunate distraction of focus from the needs of patients that these treatments were designed to serve. Furthermore, the current guideline reinforces the false notion that only highly standardized treatments can effectively serve the complex clinical needs of diverse populations. One size does not fit all, and personalized approaches are needed to meet the needs of the clinically and neurobiologically heterogenous group of individuals who have suffered trauma, especially those with comorbidities and early childhood experiences of trauma, abuse, or neglect. As currently written, the APA Clinical Practice Guideline fails to meet the clinical needs of patients or enhance the knowledge and skills of clinicians.	Reviews (pp. 57-62) and further information on this will be included in Appendix H of the finalized document. Information on comorbidities in participants is included in the methods section as well (p. 62-63) so users of the guideline can check if they have any questions about applicability to their patients. The panel also noted information about applicability, including recommendations in the implementation considerations section as well as calls and recommendations for future research. Applicability was also one of the four main components of the decision making the panel used when making recommendations These four components on which the panel based their decisions about recommendations were: overall strength of the evidence, balance of benefits to potential harms, patients' values and preferences, and applicability. CPGs are one piece but not the full basis for decision-making as part of evidence-based practice in psychology. Rather, they inform the best available evidence to be considered together with clinician expertise and patients'

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		It is also more likely to limit rather than stimulate needed research and training. A major revision is required.	values, preferences, and individual characteristics Given the interest in and widespread use of psychodynamic therapies, the CPG update panel worked extra hard to look into this. Upon initial review, the panel found that there was insufficient literature that met the IOM criteria. The panel went above-and beyond the traditional CPG methods by engaging in several rounds of updated literature searches - explicitly for more literature on psychodynamic psychotherapies. Unfortunately, in spite of these significant efforts, the panel found that there was still insufficient literature that met the IOM criteria to be able to make a recommendation regarding psychodynamic approaches and other commonly used interventions/ approaches. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean

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			that it doesn't work. Rather, there was not enough specific research that met the IOM criteria.
Kirk Schneider (Individual)	General Comment	I fully support PsiAN's comment below: [PASTED COMMENTS FROM PSIAN]	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Jennifer Franklin (Individual)	General Comment	I support PsiAN's comment. I would also like to add my own comment: Reliance on evidence-based treatments is in general a problem when it comes to the psychological and psychophysiologic care of human beings. Evidence-based treatments are not necessarily BETTER than non-evidence-based treatments; they simply meet a standard by which they can be studied reliably. There is a great deal of anecdotal support for other approaches, especially more experiential, somatic, mindful, and/or organic methods, by the clinicians who work on a regular basis with patients who have PTSD symptoms. When I was in graduate school, I read a number of anecdotal reports on the benefits of mindfulness meditation, and years later there was suddenly empirical evidence for the benefits of mindfulness meditation. We could have been teaching clinicians how to use mindfulness approaches many years earlier had we paid more attention to the literature derived from those working day in and day out with patients. We need to find balance and mind the gap between the research and clinical. Even better when we can close the gap!	Thank you for your comment. Please see the response to PsiAN's comments above. Based on the IOM standards for clinical practice guideline (CPG) development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria. CPGs are a piece of evidence-based practice in psychology, but not the whole thing. Rather, they inform the best available evidence to be considered together with clinician expertise and patients' values, preferences, and individual characteristics.
Leisl Bryant (Individual)	General Comment	I fully support PsiAN's comment and strongly recommend APA make necessary revisions before finalizing these guidelines.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).

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Dan Prezant (Individual)	General Comment	I have significant concerns about this proposed update to the 2017 guidelines [PASTED COMMENTS FROM PSIAN].	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Tamara Werth (Individual)	General Comment	I support PSIANs comments.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Alex Tucker (Individual)	General Comment	I support PsiAN's comment	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Karen Zilberstein (Individual)	General Comment	I support PsiAN's comment	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Joan Lentz (Individual)	General Comment	I support PsiANs comments	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
James Carnelia (Individual)	General Comment	I support PsiAN's comments	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Sam Talone (Individual)	General Comment	I support PsiAN's comments.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Jason Holloway (Individual)	General Comment	We have significant concerns about this proposed update to the 2017 guidelines. Our concerns fall into four main categories, with additional detail outlined below: Problems arise from an over-reliance on systematic reviews and meta-data. Over-emphasis on exposure-based therapies results in significant limitations. The misrepresentations of the Institute of Medicine (now the National	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).

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		Academy of Medicine) framework and of APA's own definition of evidence-based treatment are a major weakness. Questions remain about the applicability of research studies to community practice. I support PsiAN's comment.	
Risa Mandell (Individual)	General Comment	I support PsiAN's position. 1. Problems arise from an over-reliance on systematic reviews and meta-data. 2. Over-emphasis on exposure-based therapies results in significant limitations. 3. The misrepresentations of the Institute of Medicine (now the National Academy of Medicine) framework and of APA's own definition of evidence-based treatment are a major weakness. 4. Questions remain about the applicability of research studies to community practice.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Joanne Marengo (Individual)	General Comment	I support PsiAn's Comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Carrie Langenbach (Individual)	General Comment	I support comments submitted by PsiAN.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Bailey Wolfs (Individual)	General Comment	I support comments submitted by PsiAN.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Carrie Eichberg, Psy.D. (Individual)	General Comment	I support PsiAN's comment!	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).

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Alyse Rynor (Individual)	General Comment	[PASTED COMMENTS FROM PSIAN]	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Melanie Wilcox (Individual)	General Comment	As a practitioner who specializes in trauma and a trauma researcher, I am extremely dismayed to see the PTSD guidelines once again substantially miss the mark. So much crucial trauma research is ignored, as is oppression-based trauma; and the implicit definition of "evidence" here is once again problematic. I wholeheartedly support PsiAN's comment and hope that the feedback will be taken seriously.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Larry Rosenberg (Group: PsiAN)	General Comment	[PASTED COMMENTS FROM PsiAN]. I am in full agreement with the above listed PsiAN's comments and concerns regarding the guidelines for treatment of PTSD.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Erica Pinney (Individual)	General Comment	As a practicing trauma therapist and researcher, I find the guidelines to have taken an overly simplified understanding of the state of trauma therapy. I wholly agree with PsiAN's detailed comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Richard Achiro (Individual)	General Comment	I support PsiAN's comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Maia Miller (Individual)	General Comment	I support PsiAN's comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Dana Baerger (Individual)	General Comment	I strongly support PsiAN's comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).

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Meghan Arthur (Individual)	General Comment	I agree with Psian's comments. How can a psychology organization erase an entire evidence base of treatment in its recommendations? Affect-based psychotherapy is essential for treating many people with PTSD.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Elizabeth Feldman (Individual)	General Comment	[PASTED COMMENTS FROM PSIAN]	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Monica Carsky (Individual)	Treatment Recommendations	Once again, the APA is putting forth a guideline based on review of meta-analyses, and thus the committee has introduced bias towards those treatments which happen to be the most studied, rather than those that have been found to be most effective. The possibility of developing guidelines that are clinically useful and meaningful to a generalizable group of patients in a variety of treatment settings is significantly diminished. The approach taken in developing this guideline predetermined the exclusion of psychodynamic psychotherapy, thus undercutting the use of a valuable and widely utilized clinical approach to PTSD that should be available as an equal option for PTSD treatment. I support PsiAN's comments.	Thank you for your comment. Given the interest in and widespread use of psychodynamic therapies, the CPG update panel worked extra hard to look into this. Upon initial review, the panel found that there was insufficient literature that met the IOM criteria. The panel went above-and beyond the traditional CPG methods by engaging in several rounds of updated literature searches - explicitly for more literature on psychodynamic psychotherapies. Unfortunately, in spite of these significant efforts, the panel found that there was still insufficient literature that met the IOM criteria to be able to make a recommendation regarding psychodynamic approaches and other commonly used interventions/ approaches.

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			Please also see the response to the PsiAN comments above.
Thomas Guiliano (Individual)	General Comment	I support PsiAN's comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Miriam Lorrain (Individual)	General Comment	I support PsiAN's comment.	Thank you for your review. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Lili R. Sznaidman, MS, LCMHCS (Individual)	General Comment	I support PsiaN's comments related to APA's recommendation of treatment modalities based on their selection of research studies for the following reasons: 1-Problems arise from an over-reliance on systematic reviews and meta-data. 2. Over-emphasis on exposure-based therapies results in significant limitations. By focusing primarily –if not exclusively, on highly manualized treatments, APA leans towards medical models of treatment in a field. While closely related, mental health fields also distinguish themselves from medical ones by the understanding and treatment of conditions that require both, increased attention to individual case conceptualizations and a deeper understanding of the mind beyond symptomatology.	Thank you for your comment. Please see the response to the PsiAN comments above.
Nam Phuong Nguyen (Individual)	General Comment	I support PsiAN's comment	Thank you for your comment. Please refer to the Panel's responses to comments submitted by Linda Michaels (Group: PsiAN).
Jessica Punzo (Individual)	General Comment	I support PsiANs comments and strongly urge the APA to get additional feedback and guidance from other trauma experts within the APA, specifically those within the dedicated division within APA for trauma psychology - Division 56. It is concerning	Thank you for your comment. Please see the response to the PsiAN comment above.

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		that they did not involve or consult this Division at all in the creation of this document.	Outreach to and member involvement of Division 56 was as follows: <u>Call for Nominations to Serve on PTSD CPG Panel:</u> • Calls for nominations were sent to Div 56 listserv on 8/17/2020 and 9/24/2020. <u>PTSD CPG Panel Membership:</u> • From the outreach, ultimately 3 members of the final appointed panel out of 12 were Division 56 members. This is 25 % of the total multidisciplinary panel membership. When looking at only the psychologist members it is 3 out of 7 that are Div 56 members. • These members are: o Dr. Nnamdi Pole (represents Div 56 to Council) o Dr. Elana Newman o Dr. Bita Ghafoori <u>First Call for Public Comments:</u> • Call for comments on 30-day comment period on the initial scoping and systematic review decisions was sent to Div 56 on 3/21/2023. (Later, an extension to

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			the call deadline was given to allow a past president of Div 56 and anyone in Division 56 to submit comments for one week after the initial deadline because it was noted that the initial email that was sent directly to Div 56 was never approved by the Div 56 listserv moderator to have it disseminated to their list.) <u>Second Call for Public Comments:</u> • Since the time of the first call for public comments, APA Staff were advised to no longer email APA divisions directly and instead to communicate with them via submitting requests to Division Digest, which is sent to all division leaders. The call for comments was submitted to Division Digest and it appeared three times: in the Nov 13, Oct 23, and Oct 9 Division Digest issues.
Brooke Finley (Group: Finley Psychiatric Nurse Practitioner LLC)	Treatment Recommendations	c-PTSD is likened to personality disorder issues related to chronic traumatic events. It is important to note that psychoanalytic and psychodynamic practices have robust outcomes for allowing for personality change and psychic structure in the treatment of personality disorders.	Thank you for your comment. Please refer to the response to PsiAN's comment above.

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		I support PsiAN's comment. Do not forget psychodynamic and depth psychotherapies.	
Christine A. Courtois, Ph.D., ABPP (Individual)	General Comment	Thank you for the opportunity to review this draft and to provide reactions and commentary. In general, I was pleased at what are responses to many of the critiques of the previous guideline for PTSD, for which I served as chair. Many of these critiques can be found in the two special issues of the journals Psychotherapy (Courtois & Brown, 2019) and Innovations in Clinical Practice (Brown & Courtois, 2019), published jointly and commissioned by the journals' editors, and involving a diverse array of invited authors. Although this revision makes treatment recommendations that basically mimic those of the 2017 document--even as it relies on an expanding and evolving research base--the commentary is much more broad-based and inclusive of many issues of importance. In particular, the inclusion of CPTSD and the ongoing attention to the individual's contextual factors, culture, ethnicity, personal characteristics, personality, and personal experience in this document, expand its scope considerably to a broader group of the population of concern. That said, I join in the main concerns raised in the letter from Psychotherapy Action Network, namely 1) the over-reliance on systematic reviews and meta-data (due to the fact that APA made the decision to use the IOM standards although it is still not clear whether they are as applicable to psychology/behavioral health as they are to medicine;	Thank you very much for your service and time in chairing the original APA PTSD CPG panel as well as in providing feedback to help the update panel in its work on the current guideline. It is heartening to hear that you found this guideline to be responsive to the critiques of the original guideline which you chaired. The feedback on the previous guideline was very helpful in shaping and informing the current guideline. Thank you for your note that you support the Psychotherapy Action Network letter. Please refer to our response to that letter above. Thank you as well for your work chairing the CPTSD PPG.

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		2) the over-emphasis on certain types of exposure-based therapies, although mention was made of others and the general importance of some sort of exposure in many cases; 3) related to #1, the under-recognition of APA's own definition of evidence-based treatment as relying on three factors and not only on research: 1) clinical judgement, experience, and consensus, 2) patient preference, and 3) research data (although the guideline gave recognition to the recently accepted APA Professional Practice Guidelines for PTSD and the one directed at CPTSD —the latter which I chaired--which were more in line with the APA definition of evidence-base); and, 4) the ongoing questions about the general applicability of research studies to community practice. Additionally, I share the concern that affect-based and more in-depth treatments, the impact of the relationship on treatment for traumatized individuals, the non-inclusion of alternate types of research design, and an overreliance on RCT and meta-data are still not given enough emphasis in this guideline. In particular, the wholesale applicability of exposure based treatments and their timing is an open question and the subject of considerable debate at present, especially as concerns developmental trauma and CPTSD Disturbances of Self Organization (DSOs). More emphasis on the possible overreliance on a small number of exposure treatments and their possible adverse impact on this sub-population certainly deserves more mention and more study. There is risk in this strategy due to the	

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		fact that such techniques may be aversive and even damaging to the more complexly and cumulatively/developmentally traumatized and that a focus on developmental issues, skills development, and DSOs (as described in the ICD-11 criteria for CPTSD, including more recognition of relational disturbances such as in social and intimate relationships and ability to parent), and the treatment of underlying cognitive errors and beliefs along with depression, may prove to be more effective. Those of us who espouse a broader set of treatment approaches for CPTSD often feel like we are speaking heresy for not fully endorsing more directed and manualized exposure techniques. This is not to put down the efficacy of exposure based techniques in many cases, however, is an attempt to address possible limitations. As recognized, the data for different treatment alternatives for different sub-populations of the traumatized are not yet available although the research basis is in development and growing.	
Wendy Marisol Wolf (Individual)	Treatment Recommendations	I support PsiAN's comment. I feel these guidelines have introduced bias towards those treatments which happen to be the most studied, rather than those that have been found to be most effective. The possibility of developing guidelines that are clinically useful and meaningful to a generalizable group of patients in a variety of treatment settings is significantly diminished. The approach taken in developing this guideline predetermined the exclusion of psychodynamic psychotherapy, thus undercutting the use of a valuable and widely utilized clinical approach to PTSD.	Thank you for your comment. Please see the response to the PsiAN comment above.
Anthony Bram (Individual)	General Comment	I fully support PsiAN's comment. I am concerned that once again APA is disregarding its own definition of evidence-based practice (2006, 2024).	Thank you for your comment. Please see the response to the PsiAN comment above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Molly Rothenberg (Individual)	General Comment	PsiAn has provided an extensive comment on the inadequacies of the APA approach to developing its guidelines. I agree that the design is flawed in several respects, but most notably in the over-emphasis on meta-studies which, while important, fail to capture individual study quality, which biases the meta-analysis toward the most studied rather than the most effective approaches. APA has also used a mis-represented the definition of evidence-based treatment, included APA's OWN definition. Furthermore, the APA guideline, in large part because of its over-reliance on metastudies, endorses exposure therapy, which is widely used in some settijngs, such as the VA, but which has sn rxceedlingly high dropout rate and fails to alter the diagnosis of many who are deemed to have responded well to the treatment. The dropout rate and the bias toward reporting "success" even when the diagnosis remains the same are easily observed in the data, but the APA guideline neglects both problems. STudies of new treatments that are highly effective and have much lower dropout rates are ignored. PsiAN has detailed the many shortcomings of this guideline, and I agree with all of them. But the most pernicious problem of the proposed guideline from my experience of over 30 years as a clinician is that it assumes a one-size-fits-all approach that we already know is not only ineffective for many of our patients but which has the potential to HARM them. Please read the manualized treatment for trauma developed by Busch and Mirod, which is designed to foster research as well. Go back to the drawing board, folks, with PsiAN's comments taken to heart. Too many flaws and misrepresentations in the guideline's assumptions and design, as detailed by PsiAN.	Thank you for your comment. Please see the response to the PsiAN comment above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Karl Stukenberg (Individual)	General Comment	I strongly support the PsiAN comments. In addition, Courtois and Brown (2029) clearly articulated the difficulties with using IOM guidelines the last time these guidelines were published. We, as a science, have tools that allow us to evaluate the complex interventions that we provide. We don't need to import guidelines from a biological science that is treating the human brain, the most complex closed system in the known universe, as if it were any other organ in the body. It is not. The evidence from CBT trials is clear - these are not effective treatments. Just because they have been studied more does not make them more effective. APA, of all institutions, should use psychological science to describe psychological effectiveness of treatment. T	Thank you for your comment. Please see the response to the PsiAN comment above.

Section 1-B: Overreliance on Systematic Reviews / Meta-Analyses

PANEL RESPONSE:

Thank you for your comments. The APA's guideline development process follows the Institute of Medicine's (IOM, now National Academy of Medicine, 2011a) standards, a vetted and evidence-based guideline development methodology that relies on systematic reviews in order to reduce bias. However, there are a few exceptions with factors that are part of the decision-making process about recommendations; when considering harms and burdens and patients values and preferences, a broader inclusion of literature (e.g., observational) and clinician and patient expertise and experience is invited. Furthermore, all systematic reviews must also meet the IOM (2011b), AMSTAR (Shea et al., 2017), Agency for Healthcare Research and Quality (2023) or Cochrane (Higgins et al., 2024) quality criteria. Underlying this process incorporating the highest quality research and systematic reviews of that research, is APA's intention to write clinical practice guidelines that are not only trustworthy and reliable, but that, in the hands of competent clinicians, optimize mental health care for trauma survivors (Hamblen et al., 2019). The IOM (2011a) standards for guideline development are widely used and referenced in guideline development by many health care organizations, professional associations, and more across the United States, for example by the American Psychiatric Association, U.S. Preventive Services Task Force, American College of Physicians, Centers for Disease Control and Prevention, and many more. The APA resulting CPGs for PTSD in large part are consistent with those written by other professional organizations (see section in the narrative, "How the APA Compares to Other Treatment Guidelines for the Problem"). Clinical expertise was certainly a part of the clinical practice guideline decision-making. Most GUP members are experienced clinicians. Their expertise, along with data from the fifteen (15) systematic reviews and the opinions and experiences of the panel's community member were incorporated into CPG recommendations. The GUP agrees that psychological treatments, including PTSD treatments, must consider each individual patient's needs and sensibilities. The value of a scientific, evidence-based approach to guideline development is that as new scientific evidence emerges from well-conducted studies, guideline recommendations will change accordingly. The GUP encourages clinician-scientists and others to continue pursuing and publishing high-quality research on promising treatments' impact for individuals suffering the negative sequelae of trauma exposure.

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Commenter (Group or Individual?)	Section	Comment	Panel Response
Harold Kudler (Individual)	General Comment	APA's overreliance on systematic reviews in the development of its revised PTSD Guideline resulted in near total eclipse of clinical expertise by research methodology. This is "cookbook" clinical practice- and that with a very restrictive list of ingredients and techniques. Systematic reviews are, by definition, "… attempts to identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a specific research question" (Cochrane Dictionary, 2024). While systematic reviews can and should inform clinical decision making, the vast majority of patients would fail to meet such pre-specified eligibility criteria nor would the answer to a specific research question be sufficient to address the complex clinical needs of the average patient. APA's own Guidelines on Evidence-Based Psychological Practice in Health Care speak clearly to this point: APA policy calls for "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 273). This tripartite model… explicitly defines [Evidence-Based Practice in Psychology] as the intersection of high-quality research, clinical expertise, and patients' characteristics, sociocultural backgrounds, and preferences. (p.3) These sentiments are so more honored in the breach than in the proposed guideline revision that	Thank you for your comment. Please see the response to this comment topic above as well as in the response to the PsiAN letter.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		it begs the question of whether this clinical practice guideline is, in fact, still clinical. Exclusion of psychodynamic approaches is an essential case in point. In a document entitled "APA's Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update: Frequently Asked Questions" which was circulated as part of the request for outside review, considerable emphasis was placed on best practices set forth by the Institute of Medicine (IOM) (now the National Academy of Medicine) in their seminal 2011 publication, "Clinical Practice Guidelines We Can Trust". Section 9 (p.2) of APA's Frequently Asked Questions (FAQ) document addresses the question "Why are some common psychological treatments not among those being recommended?" The justification is that, "[b]ased on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria." Section 10 of APA's FAQ document addresses why psychodynamic psychotherapy was not a recommended treatment in the original guideline and is still not recommended in this updated CPG. The explanation given is that, although, "… [t]he panel went above-and beyond the traditional CPG methods by engaging in several rounds of updated literature searches", they, "found that there was still insufficient literature that met the IOM criteria to be able to make a recommendation regarding psychodynamic approaches and other commonly used interventions/ approaches". The problem with this argument is that	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		it misrepresents IOM's actual recommendations (Kudler, 2019). IOM explicitly emphasizes the importance of balancing clinical and research findings in developing clinical practice guidelines. Although they note that some authorities, including the National Institutes of Health Consensus Development Conference, have recommended that those who develop systematic reviews and those who then base guidelines upon those reviews should operate in "complete isolation" of one another "to discourage the clinical experts from biasing the SR results" (p. 93), the IOM authors go on to provide the following guidance: The [IOM] committee is critical of the isolationist approach because it inhibits knowledge exchange between clinical content experts and methodologists, potentially degrading their abilities to appreciate the nuances of evidence and clinical questions pertinent to the formulation of recommendations. (p. 96) APA's proposed Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 falls far below IOM's standard and APA's own Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care because it fails to meet (or even consider) the realities of clinical practice. If science is meant to accurately describe phenomenon in the natural world, then the methodology upon which this CPG fails as science by limiting and distorting our perspective on the clinical practices which CPGs ought to improve. As Alfred North Whitehead advised, "The aim of science is to seek the simplest explanations of complex facts. We are apt to fall into the error of thinking that the facts are simple because simplicity is the goal of our quest. The guiding motto in the life of every natural philosopher should be, Seek simplicity and distrust it" (P. 143). Clinicians cannot trust the proposed APA	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Clinical Practice Guideline as currently written. Major revision is required. REFERENCES American Psychological Association. (2006). Evidence-based practice in psychology. American Psychologist, 61(4), 271–285. https://doi.org/10.1037/0003066X.61.4.271 American Psychological Association. (2021). Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care. Retrieved from https://www.apa.org/about/policy/evidence-based-psychological-practice-health-care.pdf. American Psychiatric Association. (2024). APA's Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update. Frequently Asked Questions. Cochrane Library. (2024). About Cochrane reviews. Retrieved from https://www.cochranelibrary.com/about/about-cochrane-reviews Institute of Medicine. (2011). Clinical practice guidelines we can trust. Washington, DC: The National Academies Press. Kudler H. (2019). Clinical practice guidelines for posttraumatic stress disorder: Are they still clinical?. Psychotherapy (Chicago, Ill.), 56(3), 383–390. https://doi.org/10.1037/pst0000236.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Whitehead, A.N. (1919). The concept of nature. Cambridge University Press.	
Sheila Rauch (Individual)	General Comment	The reliance on systematic reviews is problematic as a sole foundation for CPG development. These reviews are aggregating studies designed for different purposes (target outcomes, populations, etc.) without regard for the important and clinically relevant questions that the RCTs provide more direct answers. Often the assumptions made in these aggregations are not warranted given the initial study design (such as a study powered for PCL as an outcome be aggregated in a review based on CAPS results). It would be more useful for the field to review the RCTS as well as the systematic reviews to provide the most insightful and clinically useful direction.	Thank you for your comment. Please see the response to this topic above. Many times, during the review of the Grid (Appendix J), the panel did look at individual RCTs referenced there to better contextualize the findings.
John Markowitz (Individual)	General Comment	In the absence of a panacea, and with many patients having difficulty tolerating exposure-based treatments, why limit the range of effective treatments for this debilitating disorder of growing prevalence? Yet this is what your workgroup has done, seemingly based not on the accumulation of negative findings for other treatments but on your ignoring the accumulation of positive data for these interventions. The whole premise of working from systematized reviews and meta-analyses rather than primary data is flawed. It means working with inherently old data, given the time to publication such reports require. Meta-analyses are valuable to a point, but they lose the fine grain of individual trials, including many aspects of clinical importance that are not easily abstracted into meta-analytic statistics. (I argued against this approach when I belonged to the workgroup, and it s the major reason we parted ways.) If you plan to use systematized reviews and meta-analyses, at the very least you should supplement them by reading the more	Thank you for your comment. Please see the response to this topic above and in the Psi AN letter response. Please refer to the IPT section for a response on that topic.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		recent clinical trials literature. There is no indication that your group did so. Thus your methodology has led you to favor older data about the more established exposure treatments while discounting new developments in the field. This is misguided, and misguiding for your guideline s potential future readers. Perhaps because you have not been working from primary sources, your workgroup fails to describe the actual evidence that determined your decisions. How many IPT studies did you actually review, either for veterans or civilians with PTSD, before concluding that there was insufficient evidence to recommend it? I found no mention. To make pronouncements without providing their basis adds to the sense of bias in your decisions. Several recent reports have critiqued potential expert bias in guidelines, such as the recent VA/DoD guidelines (Hoge et al.: JAMA Psychiatry 2024;81:223-224; Markowitz & Lowell: Am J Psychotherapy [in press]). APA should not add to that dismaying trend by favoring purely exposure-based treatments when evidence now supports alternatives.	
Linda Michaels (Group: PsiAN)	General Comment	**1. Approach and data selection** We believe that the evidence base upon which the guidelines have been developed is fundamentally inadequate and misleading. The APA has taken an idiosyncratic and unprecedented short-cut in not reviewing primary research and not including swaths of efficacy studies in affect-focused psychotherapies or alternate kinds of research design that provide access to information about dimensions of psychotherapy process and outcome that can illuminate what diverse patients find helpful. Meta-data/meta-analyses are designed to compare large studies using identical outcome measures across vast numbers of medical disorders, (i.e.,	Thank you for your comment. Please refer to the full response above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		approaches for diabetes, wherein the primary outcome measure, HGB A1C, is well established). They are over-used in mental health research despite well-documented problems: N's of individual studies tend to be small and the number of moving parts in mental health research are far more complex than in general medicine (i.e., research benchmarks: primary outcome measures, definitions of response and remission). (See Barber JP, Milrod B: Pitfalls of meta-analysis (letter). American Journal of Psychiatry 2004;61:1131.) While meta-analyses provide statistical power, at the same time they obscure critical elements of individual RCTs such as population, level of training of those providing the treatments under study, and methods of dealing with missing data. Importantly, meta-data cannot capture individual study quality, which is the bread and butter of efficacy research, determining which studies deliver high quality data, which could be reliably reproducible, and which are fatally biased. Meta-analyses lump all studies together, giving equal weight to studies, whether they are poorly conducted or of high quality. (See Kocsis J, Gerber A, Milrod B Roose SP, Barber JP, Thase ME, Perkins P, Leon AC: A new scale for assessing the quality of randomized clinical trials of psychotherapy. Comprehensive Psychiatry 2010 May-Jun;51(3):319-24.) By choosing to focus exclusively on systematic reviews, the committee has introduced bias towards those treatments which happen to be the most studied, rather than those that have been found to be most effective. The possibility of developing guidelines that are clinically useful and meaningful to a generalizable group of patients in a variety of treatment settings is significantly diminished.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
Paula Schnurr (Individual)	Process and Methods of the CPG	The guideline is a welcome update to the 2017 guideline. It is based on a rigorous process and that is clearly presented. However, I am concerned that some decisions about the methods may have affected the review by failing to include key studies. Specifically, by using only literature reviews, the body of evidence fails to include single studies that have not been incorporated into those reviews. A clear example is the use of the Illingworth 2021 SR on MDMA, which does not include the two key Phase 3 studies that were published after the SR (Mitchell 2021, 2023). I do not know whether these studies would have changed the evidence rating, but the fact that they exist and were not included shows that the guideline is not based on all of the available evidence. Another concern is the failure to include the Belsher 2019 Cochrane review of Present-Centered Therapy (10.1002/14651858.CD012898.pub2), which was based on 12 studies. Additional studies have been conducted since then. PCT is an active manualized psychotherapy with a rationale for the focus on how trauma impacts one's present life, homework, and specific session structure that can include a variety of therapy techniques. Although it was originally designed to control for the nonspecific benefits of psychotherapy in order to isolate the unique effects of trauma-focused psychotherapy, it is effective in its own right. The 2023 VA/DoD PTSD guideline suggests PCT ("Weak For" in GRADE terminology). It appears that the failure to include Belsher's review may have led the workgroup to making the "insufficient" recommendation for PCT. Reliance on SRs conducted by others is not a unique problem for the APA guideline. For example, the VA/DoD PTSD guideline is also based on SRs, but also includes	Thank you for your comment. At the time of the literature search for reviews that could supplement the primary review by AHRQ (Hoffman et al., 2018), the Panel was advised to look at publications 2020 and later in order to keep the guideline evidence current within the last five years, with the exception for the review by Karatzias et al. (2019) in response to the March-April 2023 30-day public comment period on the Panel's initial decisions in its scoping framework and identified systematic reviews as it addressed complex PTSD.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		individual studies that are relevant to key questions but not included in the identified SRs. I recommend that the APA workgroup attempt to determine the extent of the problem and then decide the best course of action (e.g., no action would be needed if few studies were not included and would not have changed recommendations if they had been included).	
Denise Sloan (Individual)	General Comment	The document is clearly written and thorough in its description of the process by which the guidelines were created. One key limitation is the method that was used to review studies solely relied on systematic reviews. Although it is understandable that reviews would be used in determining evidence for particular treatment protocols, solely relying on systematic reviews resulted in some important studies not being considered that probably should have been considered. In addition, there were some other approaches to evaluating the evidence for specific treatments that are confusing and resulted in the treatments not being considered "recommended." Specifically, the document indicates that treatments needed to have evidence of it's efficacy compared to waitlist conditions, but studies that were directly compared to evidence based PTSD treatments were determined to provide insufficient evidence. This is an approach that is perplexing and results in treatments that have been around for more than 10 years automatically being favored. That is, it is no longer an acceptable approach to compare an active treatment to a waitlist or not treatment comparison condition given the state of evidence for PTSD. Specifically, IRB committees and funding agencies will not permit withholding effective PTSD treatment from participants in need of such treatment. This is the right decision for patient participants. However, the committee requires studies that include	Thank you for your comment. The Panel added the following note in the rationale section: "At times when a specific-named intervention was singled out, the evidence base weakened. The balance of benefits and harms/burdens was insufficient to make a recommendation on these specific-named interventions. In particular, repackaging of previously well-established interventions that have multiple RCTs also fell into this category."

Commenter (Group or Individual?)	Section	Comment	Panel Response
		waitlist comparison conditions to recommend a treatment condition. As an overall comment, we cannot set the bar for evaluating treatments to be so high that the only treatments that will end up being included are those that have been present for several decades. The field is in dire need of additional effective PTSD treatments that can be used in the settings and with trauma samples that are in need of these treatments. The current treatments that are recommended, namely PE and CPT, are falling short and clinicians are well aware of this. When treatments that are effective are left out of being recommended by clinical practice guidelines, it has real world implications in terms of increasing difficulty of obtaining grant funding to further investigate these treatments and in terms of institutions, such as VA, not permitting clinicians to use these treatments (i.e., not counting them) for patients with PTSD. See my detailed comments to provide an example of such a treatment.	
Ian Kloss (Individual)	General Comment	I endorse PsiAN's comments expressing concern about study selection and generalizability. An over-commitment to meta-analyses as the only viable source of efficacy data is very likely to overlook treatments which would otherwise rise to the APA's standards of evidenced-based practice (i.e., which are supported by less abundant but high-quality studies and which have extensive support from expert clinicians). As it stands, the range of exposure-based interventions which are supported are poorly tolerated by many patients and may overlook important developmental and relational factors that are likely impact on treatment of patients whose PTSD is comorbid with other issues, including personality disturbance, and/or whose history includes early or complex trauma.	Thank you for your comment. Please refer to the response to this topic above as well as the broader response to the PsiAN letter.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Jessica Hamblen (Individual)	General Comment	Although a best practice, I agree with other reviewers that relying on systematic reviews can be problematic. Studies can be left out and miscategorized. It can also be difficult to look at critical outcomes if systematic reviews are designed to answer your specific questions. For example, the SR by Jericho prioritized self report over clinician-rated PTSD, a decision that most who argue creates more bias because the assessor (the client) is not blind to condition. I was confused by the date of the range of the literature review. It appears you went back 5 years. I would encourage you to at least go back to the end of your last CPG and then also consider the literature findings from that review. While you would hope that current reviews would pick up studies in the interim, this would ensure greater coverage.	Thank you for your comment. Please refer to the overall response at the beginning of this section. The search dates for the literature review correspond to the dates the systematic reviews/meta-analyses were published. The Panel was limited to the methods employed by the authors of the reviews in terms of date ranges of individual studies' publications.

Section 2: Seeking Safety

Commenter (Group or Individual?)	Section	Comment	Panel Response
Lisa M. Najavits, PhD (Individual)	Treatment Recommendations	11/22/2024 To: APA CPG committee From: Lisa M. Najavits, PhD Re: APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update I appreciate the opportunity to offer detailed comments on the above CPG draft. My serious concern is that the only psychological intervention identified as "not recommended," among a total of 34 psychological interventions, is Seeking Safety. I will outline here specific evidence to support reevaluating that rating. Also the psychological treatments listed as "first line / strong for" on PTSD/SUD warrant a second look as they do not appear to have sufficient evidence to support that recommendation. PTSD/SUD is one of the most common comorbidities and a major public health and clinical challenge. Yet PTSD/SUD treatment research is a relatively new area of study, with far fewer studies compared to PTSD-alone treatment research; it's thus essential not to draw premature conclusions. Details are below and in the Appendix to this letter. **Sherman et al. (2023) meta-analysis of Seeking Safety**	Thank you for your comment. After reviewing your feedback, the panel re-visited its recommendation about Seeking Safety, re-examined the data and voted to change the recommendation as noted: **Level**: Other Treatments Reviewed **Recommendation Statement**: For patients with PTSD and comorbid SUD [substance use disorder], evidence indicates **no difference in effect** on PTSD symptoms or substance use for the following interventions **over a TAU for SUD intervention**. Thus, the panel makes **no recommendation** for or against the following interventions listed: ❖ Seeking Safety ❖ Seeking Safety plus TAU **Strength/Direction**: No difference in effect **Rationale**: Findings indicate no difference in effect for critical outcomes, no information or unclear effect on important outcomes. There was no evidence of differential harms/burdens although there is variability in the TAU category. The balance of benefits to

Commenter (Group or Individual?)	Section	Comment	Panel Response
		A recent and detailed meta-analysis by Sherman et al. (2023) (an independent research team not associated with me) focused solely on Seeking Safety. It was in the CPG reference list (pg. 146) but nowhere else in the CPG draft nor CPG Grid. Notably, Sherman et al. came to much more positive conclusions than the CPG and Roberts et al. (2022). I understand the CPG methodology and the rationale for restricting its number of reviews. However, a "not recommended" conclusion warrants a deeper dive into Seeking Safety evidence per se, which Sherman et al. provide. Sherman, A. D. F., Balthazar, M., Zhang, W., Febres-Cordero, S., Clark, K. D., Klepper, M., Coleman, M., & Kelly, U. (2023). Seeking safety intervention for comorbid post-traumatic stress and substance use disorder: A meta-analysis. *Brain and Behavior, 13*(5), Article 3187 e2999. https://doi.org/10.1002/brb3.2999 https://onlinelibrary.wiley.com/doi/full/10.1002/brb3.2999 A brief summary of their conclusions is as follows. This letter's Appendix provides additional detail. • "for PTSD, significant effects were found at immediately postintervention, at 6 months, and 9 months by group (p = .003, p = .0005, p = .002, respectively), time (p = .001, p = .0001, p = .002, respectively) and time by group interactions (p = .02, p = .02, p = .0004, respectively)." [pg. 10] • "SS had medium to large effects on PTSD symptoms by time, group, or time by group (except for the group effect at 3-month follow-up)." [pgs. 9-10].	harms/burdens is the same for seeking safety as control. The panel further reviewed the individual studies that were identified in Roberts et al. (2022) and have concluded that the "plus TAU For SUD" modifier for the comparison "Seeking Safety plus TAU for SUD vs. TAU for SUD" comparison provided the most accurate representation of the included studies. Most of the studies (i.e., 5 of 6) were either TAU for SUD (n=4) or relapse prevention (n=2). Three of the six identified studies were Seeking Safety + TAU for SUD and two studies were Seeking Safety combined with TAU (not for SUD specifically). The panel agreed to remove the "plus TAU for SUD" modifier for the Creating Change vs. Seeking Safety comparison. Regarding the point on "moderate SOE" for Trauma-Focused CBT for comorbid PTSD and SUD, this information was pulled from the AHRQ (Hoffman 2018) review and was used during the Panel's decision-making. In Appendix J, this data point was initially under the Trauma-Focused CBT umbrella (column v) but has now been moved under the column

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• "Our findings suggest that SS is an effective intervention for the comorbid treatment PTSD and SUD across various settings and among diverse populations." [pg. 11]. • "SS has been particularly notable in being studied in real-world community-based settings, with frontline providers, and a high level of minority representation." [pg. 11]. • "All the RCTs included in this evaluation of the effects of SS had low risk of bias, which adds considerable strength to the evidence of the effectiveness of SS in the treatment of comorbid PTSD and SUD." [pg. 11]. **Sherman et al. (2023) meta-analysis of Seeking Safety (APPENDIX)** Sherman, A. D. F., Balthazar, M., Zhang, W., Febres-Cordero, S., Clark, K. D., Klepper, M., Coleman, M., & Kelly, U. (2023). Seeking safety intervention for comorbid post-traumatic stress and substance use disorder: A meta-analysis. *Brain and Behavior, 13*(5), Article 3187 e2999. https://doi.org/10.1002/brb3.2999 https://onlinelibrary.wiley.com/doi/full/10.1002/brb3.2999 From the study abstract: **Results:** Based on effect sizes (ES), meta-analysis revealed that SS has a medium group, time (p = .04), and time by group effect on substance use per the Addiction Severity Index at 3 months and a small effect on Clinician-Administered PTSD Scale scores by group, a large effect by time, and amedium time by group (p = .002) effect at 6 months. Based on the pooled ES examining various measures across multiple timepoints, SS had small tomedium effects on substance use by time, group, or time by group and medium to	"Trauma-Focused Treatments plus TAU for SUD vs. TAU intervention for SUD only" (Column AM) within the Grid for further clarification.

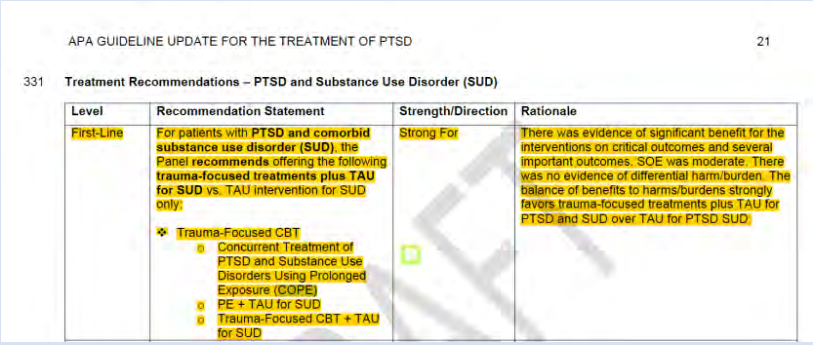
Commenter (Group or Individual?)	Section	Comment	Panel Response
		large effects on PTSD symptoms by time, group, or time by group (except for the group effect at 3-month follow-up). Significant effects were found for substance use by time at 3 and 6 months and for PTSD postintervention, at 6 months and 9 months by group, time, and time by group while only by time at 3 months. Meta-regression revealed that partial dose versions of SS generally function as well as the full dose version of SS when observing long-term effects (greater than 3 months). [pg. 1] See table 1 below. **Sherman supplemental table** *Notes:* • *"Full" refers to studies that used all 25 topics from Seeking Safety; "condensed" were studies that used only a partial dose of the model.* • *Sherman et al. conducted 2 meta-analyses. The second is the pooled ES examining various measures at multiple timepoints; it is the most robust as it included the largest number of studies. The Table below shows those results. The first meta-analysis used only 3 studies (and even with that, had some interesting findings, per the study Abstract above).* *Yellow highlights in the Table indicate significant results; blue indicates a notable finding even if not statistically significant. Highlights address only group x time results; but group / time results (separately) also evidence significant results.*	

Supplemental Table 1. Meta-analysis results comparing the group, time, and time by group effects of Seeking Safety on substance use and PTSD measures from baseline to post intervention, at 3-, 6-, and 9-month follow-up and by Seeking Safety version (full versus abbreviated)

Outcomes	Comparisons	I^2			τ^2			P (heterogeneity)			Standardized mean difference			95% CI			k			P (random effect)
	Version	Full	Condensed	All	Full	Condensed	All	Full	Condensed	All	Full	Condensed	All	Full	Condensed	All	Full	Condensed	All	All
Substance use post intervention	Group	-	0%	70%	-	0.0065	0.1345	-	0.44	0.04*	-0.71	-0.03	-0.21	[-1.19; -0.23]	[-1.29; 1.22]	[-1.28; 0.85]	1	2	3	0.48
	Time	-	0%	0%	-	0.0020	0.0008	-	0.57	0.85	-0.10	-0.14	-0.13	[-0.54; 0.33]	[-1.02; 0.75]	[-0.32; 0.06]	1	2	3	0.10
	Group by time	-	97%	96%	-	2.1826	1.9564	-	**	**	-1.26	0.39	-0.16	[-1.77; 0.75]	[-13.22; 14.00]	[-3.72; 3.40]	1	2	3	0.86
PTSD post intervention	Group	0%	18%	0%	0.0062	0.0311	0.0203	0.79	0.30	0.63	-0.38	-0.20	-0.30	[-0.58; -0.19]	[-0.74; 0.34]	[-0.46; -0.14]	5	3	8	0.003**
	Time	29%	0%	33%	0.0385	0.0038	0.0357	0.23	0.58	0.17	-0.58	-0.32	-0.46	[-0.91; -0.24]	[-0.60; -0.03]	-0.67; -0.25]	5	3	8	0.001**
	Group by time	80%	93%	93%	0.2867	0.2866	0.6194	**	**	**	-1.35	-0.18	-0.90	[-2.09; -0.61]	[-1.61; 1.25]	[-1.59; -0.21]	5	3	8	0.02*
Substance use at 3 months	Group	-	0%	30%	-	0.0009	0.0379	-	0.84	0.23	-0.52	-0.04	-0.14	[-0.96; -0.08]	[-0.21; 0.12]	[-0.50; 0.21]	1	3	4	0.28
	Time	-	0%	0%	-	0.0002	0.0019	-	0.92	0.86	-0.42	-0.24	-0.26	[-0.83; 0.00]	[-0.35; -0.13]	[-0.40; -0.13]	1	3	4	0.008**
	Group by time	-	93%	90%	-	0.3537	0.2534	-	**	**	-0.45	-0.11	-0.20	[-0.85; -0.05]	[-1.68; 1.46]	[-1.06; 0.66]	1	3	4	0.52
PTSD at 3 months	Group	0%	0%	0%	0.0057	0.0022	0.0107	0.65	0.79	0.72	0.08	-0.15	-0.11	[-0.34; 0.50]	[-0.27; -0.03]	[-0.23; 0.01]	3	5	8	0.08
	Time	11%	93%	89%	0.0287	0.2461	0.1635	0.32	**	**	-0.53	-0.80	-0.72	[-1.19; 0.13]	[-1.45; -0.14]	[-1.09; -0.34]	3	5	8	0.003**
	Group by time	0%	97%	96%	0.0012	0.8816	0.4949	0.85	**	**	-0.18	-0.30	-0.25	[-0.42; 0.07]	[-1.49; 0.89]	[-0.86; 0.37]	3	5	8	0.37
Substance use at 6 months	Group	46%	0%	16%	0.0820	<0.0001	0.0367	0.16	0.79	0.31	-0.30	-0.16	-0.23	[-1.22; 0.61]	[-0.49; 0.16]	[-0.53; 0.06]	3	2	5	0.09
	Time	33%	0%	0%	0.0385	0.0034	0.0184	0.23	0.39	0.42	-0.37	-0.29	-0.32	[-1.08; 0.34]	[-1.29; 0.70]	[-0.55; -0.10]	3	2	5	0.02*
	Group by time	96%	0%	96%	1.9815	<0.0001	1.6354	**	0.96	**	0.10	-1.40	-0.51	[-3.49; 3.69]	[-1.46; -1.34]	[-2.13; 1.11]	3	2	5	0.43
PTSD at 6 months	Group	0%	0%	0%	0.0200	0.0024	0.0119	0.58	0.69	0.78	-0.24	-0.22	-0.23	[-0.43; -0.05]	[-0.37; -0.07]	[-0.33; -0.13]	8	4	12	0.0005***
	Time	0%	95%	85%	0.0188	0.3741	0.1381	0.58	**	**	-0.55	-0.89	-0.69	[-0.73; -0.37]	[-1.89; 0.11]	[-0.96; -0.42]	8	4	12	0.0001***

	Group by time	95%	98%	96%	1.2502	1.0874	1.1230	**	**	**	-0.97	-0.60	-0.84	[-1.94; -0.01]	[-2.27; 1.08]	[-.53; -0.15]	8	4	12	0.02*
Substance use at 9 months	Group	0%	-	0%	0.0092	-	0.0092	0.45	-	0.45	-0.33	-	-0.33	[-2.13; 1.47]	-	[-2.13; 1.47]	2	0	2	0.26
	Time	57%	-	57%	0.0818	-	0.0818	0.13	-	0.13	-0.24	-	-0.24	[-3.73; 3.24]	-	[-3.73; 3.24]	2	0	2	0.54
	Group by time	67%	-	67%	0.1274	-	0.1274	0.08	-	0.08	0.19	-	0.19	[-3.94; 4.32]		[-3.94; 4.32]	2	0	2	0.66
PTSD at 9 months	Group	0%	-	0%	0.0231	-	0.0231	0.59	-	0.59	-0.45	-	-0.45	[-0.66; -0.24]	-	[-0.66; -0.24]	7	0	7	0.002**
	Time	70%	-	70%	0.1410	-	0.1410	**	-	**	-0.85	-	-0.85	[-1.26; -0.44]	-	[-1.26; -0.44]	7	0	7	0.002**
	Group by time	79%	-	79%	0.3589	-	0.3589	**	-	**	-1.75	-	-1.75	[-2.37; -1.13]	-	[-2.37; -1.13]	7	0	7	0.0004***

*p<0.05, **p<0.01, ***p<.001.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Roberts et al. (2022) The CPG, pg. 21, recommends "Trauma-focused CBT" for PTSD/SUD as "*first line / strong for,"* which was based on Roberts et al. (2022) per the CPG Appendix Table. But the conclusions highlighted in orange below do not appear accurate in terms of the actual evidence in Roberts et al. (2022).  APA GUIDELINE UPDATE FOR THE TREATMENT OF PTSD 21 331 **Treatment Recommendations – PTSD and Substance Use Disorder (SUD)** Level / Recommendation Statement / Strength/Direction / Rationale First-Line / For patients with **PTSD and comorbid substance use disorder (SUD)**, the Panel **recommends** offering the following **trauma-focused treatments plus TAU for SUD** vs. TAU intervention for SUD only: ❖ Trauma-Focused CBT ○ Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) ○ PE + TAU for SUD ○ Trauma-Focused CBT + TAU for SUD / Strong For / There was evidence of significant benefit for the interventions on critical outcomes and several important outcomes. SOE was moderate. There was no evidence of differential harm/burden. The balance of benefits to harms/burdens strongly favors trauma-focused treatments plus TAU for PTSD and SUD over TAU for PTSD SUD. Roberts, N. P., Lotzin, A., & Schäfer, I. (2022). A systematic review and meta-analysis of psychological interventions for comorbid post-traumatic stress disorder and substance use disorder. *European Journal of Psychotraumatology*, *13*(1). https://doi.org/10.1080/20008198.2022.2041831 https://pmc.ncbi.nlm.nih.gov/articles/PMC9090345/ Roberts et al. (2022) concluded the following (for additional details, see the Appendix to this letter). **Strength of evidence**	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• The strength of evidence for every study of trauma focused therapies (TFTs) was graded "very low" (the lowest possible rating). These same ratings are in the CPG Appendix Grid. (Indeed per Table 2 in Roberts, every study in their entire PTSD/SUD meta-analysis had "very low" or "low" ratings.) *Yet pg. 21 of the CPG [screenshot above], the Rationale section, lists SOE as "moderate"; it should state "SOE was very low" for TFTs.* • Pg. 17, they conclude: "GRADE judgements for all positive findings were very low, indicating that we are very uncertain about these estimated effects, which are very likely to change as further studies are reported." *It seems prudent to add a caveat to pg. 21 of the CPG, Rationale section to state, "findings are very uncertain and likely to change"; and "strongly favors" should be removed.* **PTSD outcomes** • "In meta-analysis, we found a significant difference in favor of trauma-focused intervention plus SUD intervention for PTSD severity post-treatment [when compared against intervention for SUD only]…(GRADE very low). This effect did not reach our threshold for clinical importance" [pg. 13]. • "Conclusion: There is evidence that trauma-focused therapy…can improve PTSD for some individuals, but many patients do not fully engage with treatment and average treatment effects are modest." [pg. 1].	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		The CPG, pg. 21, states that "the balance of benefits to harms/burdens strongly favors TFTs…", which is contradicted by the first bullet point above re TFT results not reaching clinical importance. The lack of clinical importance was listed in the CPG Appendix Grid (rows 3 and 59 column AN) but not in the CPG Draft. The TFTs were always combined with SUD interventions. This should be stated in the Rationale section as it means there's no evidence for the TFTs to be implemented on their own without combining them with a SUD intervention. *"TAU" was in some cases manualized models (e.g., Foa et al., 2013 used the SUD model called BRENDA, a published manual). This would be good to clarify in the Rationale as well.* *In sum, "first line / strong for" and "SOE moderate" for TFTs in the CPG Draft are not aligned with the evidence.* **The COPE model** • "A subgroup analysis of studies evaluating the COPE model showed no benefit on any of our primary outcomes over SUD-based intervention alone." [pg. 17]. • "For studies evaluating COPE, there were no post-treatment differences for PTSD… alcohol use… or drug use" [pg. 13]. *To list COPE as "first line / strong for" appears highly inaccurate. It should state instead, "COPE did not outperform SUD-interventions alone on PTSD, alcohol or drug use at end of treatment." An*	

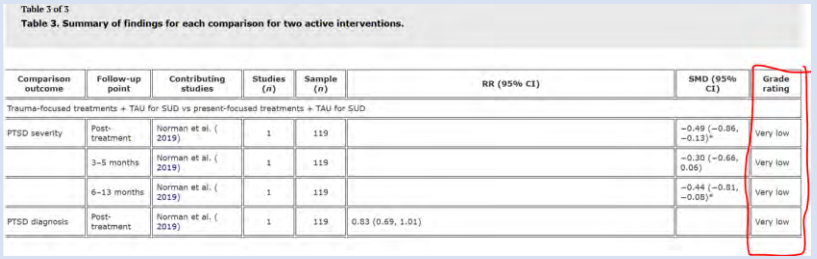
Commenter (Group or Individual?)	Section	Comment	Panel Response
		accurate rating would thus be: neither for nor against, i.e., current evidence is insufficient. **COPE versus Seeking Safety** • Only one study compared a TFT (COPE) to Seeking Safety (Norman et al., 2019). "There was a significant difference in favour of trauma-focused intervention plus SUD intervention for PTSD severity post-treatment (*N* = 119; SMD −0.49, 95% CI −0.86, −0.13) and at 6–13 months (*N* = 119; SMD −0.44, 95% CI −0.81, −0.08), but not at 3–5 months. There were no differences for alcohol use, dropout, or adverse events." [pg. 13] • Moreover, "evidence from the Norman et al. (2019) study indicates that differences in PTSD outcomes in favour of trauma-focused over present-focused therapy intervention [Seeking Safety] were only evident for participants who completed all or most of their treatment sessions (Straus et al., 2022)." [pg. 18]. *The above points makes the CPG recommendations all the more puzzling: COPE is listed as "first line / strong for" and Seeking Safety "not recommended" when the only head-to-head study of them showed the effect sizes differences on PTSD were small (less than .50), only occurred for treatment completers; the models don't differ on SUD outcomes; and, drawing recommendations from just one study is premature.* **Substance use outcomes**	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• For TFTs: "No differences were observed for alcohol or drug use, beyond those achieved for SUD only intervention, apart from a small effect for alcohol use in favour of trauma-focused intervention at 6–13 months." [pg. 13] *This should be stated in the Rationale section as a caveat, i.e., TFTs do not impact SUD beyond SUD-only interventions.* *[Note: the "small effect" above did not reach Roberts et al.'s criterion for clinical importance and, moreover, it occurred only late in followup.]* **Individual versus group modality** • "Trauma-focused therapy was delivered individually in all studies" vs "Seeking Safety was delivered through groups, apart from in Hien et al. (2004)." [pg. 7]. *Research shows that it's easier to obtain stronger effects from individual modality than from group (I can send cites if you need it). This difference in modality should be mentioned in Rationale as a caveat.* **Dropout** • "We found a relatively high level of dropout across studies." *This should be mentioned in the CPG Rationale section as a caveat.* **Caution and exclusion of severe populations** • "…clinicians should continue to exercise caution when considering whether to provide the interventions identified in	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		this review, as it is unlikely that these interventions will be appropriate for everyone and individual treatment planning will need to be guided by an individual formulation, which takes account of the predictors of outcome, alongside patient-related priorities, risk factors, and preferences (Roberts et al., 2020)." [pgs. 18-19] • "The studies included in this review mostly continued to exclude on the basis of cognitive impairment, current suicide risk, and severe mental illness, and our findings should not be generalized to individuals with these types of presentation." [pg. 19] These cautions and exclusions should be mentioned in the Rationale section as a caveat. The CPG Appendix Grid states that TFT studies excluded participants with severe SUD (rows 102 and 111, column AN) and this should be listed as a caveat as well. **Additional notes re Roberts et al. (2022):** • With regard to Seeking Safety, the CPG pg. 21 and the Appendix Grid incorrectly list "SS + TAU for SUD" and elsewhere. This appears to arises from a discrepancy in Roberts: Table 1 correctly lists the comparison as "TAU" but Table 2 incorrectly lists "TAU for SUD" even though most studies of Seeking Safety were compared with TAU, not TAU for SUD." This should be corrected. (The same holds for the incorrect listing of "Creating Change + TAU for SUD" on the CPG pg. 21.) It's an important correction because the CPG Appendix Grid repeatedly states that Seeking Safety did not outperform "TAU for SUD only" on	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		various measures, but the comparison was TAU per se, which is more heterogeneous. • See this letter's Appendix provides the full paragraph describing all results for TFTs in Roberts et al. (2022). **Roberts et al. (2022; APPENDIX):** Roberts, N. P., Lotzin, A., & Schäfer, I. (2022). A systematic review and meta-analysis of psychological interventions for comorbid post-traumatic stress disorder and substance use disorder. *European Journal of Psychotraumatology*, *13*(1). https://doi.org/10.1080/20008198.2022.2041831 https://www.tandfonline.com/doi/full/10.1080/20008198.2022.2041831#d1e606 • The entire summary of results for TFTs per Roberts et al. (2022): "In meta-analysis, we found a significant difference in favour of trauma-focused intervention plus SUD intervention for PTSD severity post-treatment (*K* = 7; *N* = 544; SMD −0.36, 95% CI −0.64, −0.08; *I*2 = 54%; GRADE very low). This effect did not reach our threshold for clinical importance. Findings based on three studies were not significant at 3–5 months but were significant, in favour of trauma-focused intervention, at 6–13 months (*K* = 5; *N* = 469; SMD −0.48, 95% CI −0.81, −0.15; *I*2 = 62%; GRADE very low). There was also a difference in favour of trauma-focused intervention for PTSD diagnosis post-treatment based on outcomes from two studies (*K* = 2; *N* = 201; RR 0.62, 95% CI 0.46, 0.84; *I*2 = 30%; GRADE very low).	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		No differences were observed for alcohol or drug use, beyond those achieved for SUD-only intervention, apart from a small effect for alcohol use in favour of trauma-focused intervention at 6–13 months (*K* = 4; *N* = 363; SMD −0.23, 95% CI −0.44, −0.02; *I*2 = 0%; GRADE very low). No differences were observed for treatment dropout or adverse effects. Adverse events were not reported for Coffey et al. (2006) and Coffey et al. (2016). In view of the limited number of studies, we only investigated subgroup differences by intervention model. For studies evaluating COPE, there were no post-treatment differences for PTSD (*K* = 3; *N* = 190; SMD −0.31, 95% CI −0.93, 0.32; *I*2 = 74%; GRADE very low), alcohol use (*K* = 1; *N* = 23; SMD 0.07, 95% CI −0.76, 0.91; GRADE very low), or drug use (*K* = 3; *N* = 170; SMD −0.16, 95% CI −0.63, 0.95; *I*2 = 81%; GRADE very low).” [pg. 13]. *In sum, positive results were limited (not clinically important), were based on few studies, or were at distant followup points (and during followup time periods one doesn’t know what types of interventions patients are receiving).* • Table 2 shows that *every study of TFTs is graded “very low.”* [Note this table displays in the online version of the article; see link above] From Table 2, just TFT studies [pgs. 11-12]:	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Table 2 of 3 **Table 2. Summary of meta-analysis of results for each comparison for an experimental psychological intervention vs a substance use disorder (SUD)-based or treatment as usual (TAU) control.** • Table 3: the only study comparing TFT to any present-focused model (it was Seeking Safety)  • Morever, *every* study in the meta-analysis has *low* or *very low* grade ratings. Table 2 with all studies:	

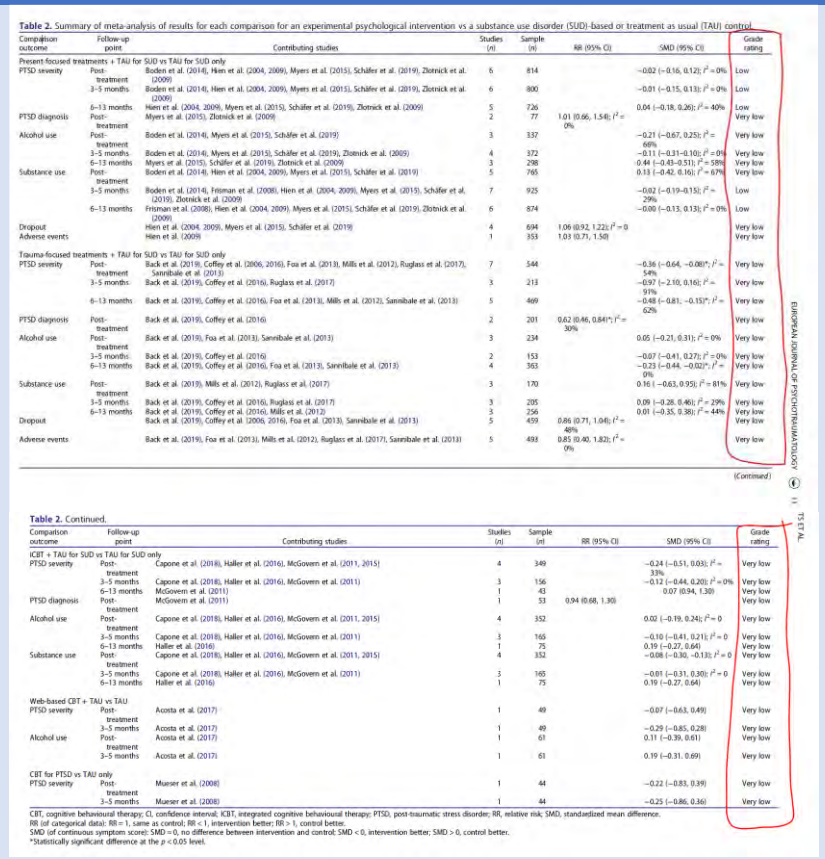
Commenter (Group or Individual?)	Section	Comment	Panel Response
			

Table 2. Summary of meta-analysis of results for each comparison for an experimental psychological intervention vs a substance use disorder (SUD)-based or treatment as usual (TAU) control.

Comparison outcome	Follow-up point	Contributing studies	Studies (n)	Sample (n)	RR (95% CI)	SMD (95% CI)	Grade rating
Present-focused treatments + TAU for SUD vs TAU for SUD only							
PTSD severity	Post-treatment	Boden et al. (2014), Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	6	814		−0.02 (−0.16, 0.12); I^2 = 0%	Low
	3–5 months	Boden et al. (2014), Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	6	800		−0.01 (−0.15, 0.13); I^2 = 0%	Low
	6–13 months	Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	5	726		0.04 (−0.18, 0.26); I^2 = 40%	Low
PTSD diagnosis	Post-treatment	Myers et al. (2015), Zlotnick et al. (2009)	2	77	1.01 (0.66, 1.54); I^2 = 0%		Very low
Alcohol use	Post-treatment	Boden et al. (2014), Myers et al. (2015), Schäfer et al. (2019)	3	337		−0.21 (−0.67, 0.25); I^2 = 68%	Very low
	3–5 months	Boden et al. (2014), Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	4	372		−0.11 (−0.31–0.10); I^2 = 0%	Very low
	6–13 months	Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	3	298		0.44 (−0.43–0.51); I^2 = 58%	Very low
Substance use	Post-treatment	Boden et al. (2014), Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019)	5	765		0.13 (−0.42, 0.16); I^2 = 67%	Very low
	3–5 months	Boden et al. (2014), Frisman et al. (2008), Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	7	925		−0.02 (−0.19–0.15); I^2 = 29%	Low
	6–13 months	Frisman et al. (2008), Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019), Zlotnick et al. (2009)	6	874		−0.00 (−0.13, 0.13); I^2 = 0%	Low
Dropout		Hien et al. (2004, 2009), Myers et al. (2015), Schäfer et al. (2019)	4	694	1.06 (0.92, 1.22); I^2 = 0		Very low
Adverse events		Hien et al. (2009)	1	353	1.03 (0.71, 1.50)		Very low
Trauma-focused treatments + TAU for SUD vs TAU for SUD only							
PTSD severity	Post-treatment	Back et al. (2019), Coffey et al. (2006, 2016), Foa et al. (2013), Mills et al. (2012), Ruglass et al. (2017), Sannibale et al. (2013)	7	544		−0.36 (−0.64, −0.08)*; I^2 = 54%	Very low
	3–5 months	Back et al. (2019), Coffey et al. (2016), Ruglass et al. (2017)	3	213		−0.97 (−2.10, 0.16); I^2 = 91%	Very low
	6–13 months	Back et al. (2019), Coffey et al. (2016), Foa et al. (2013), Mills et al. (2012), Sannibale et al. (2013)	5	469		−0.48 (−0.81, −0.15)*; I^2 = 62%	Very low
PTSD diagnosis	Post-treatment	Back et al. (2019), Coffey et al. (2016)	2	201	0.62 (0.46, 0.84)*; I^2 = 30%		Very low
Alcohol use	Post-treatment	Back et al. (2019), Foa et al. (2013), Sannibale et al. (2013)	3	234		0.05 (−0.21, 0.31); I^2 = 0%	Very low
	3–5 months	Back et al. (2019), Coffey et al. (2016)	2	153		−0.07 (−0.41, 0.27); I^2 = 0%	Very low
	6–13 months	Back et al. (2019), Coffey et al. (2016), Foa et al. (2013), Sannibale et al. (2013)	4	363		−0.23 (−0.44, −0.02)*; I^2 = 0%	Very low
Substance use	Post-treatment	Back et al. (2019), Mills et al. (2012), Ruglass et al. (2017)	3	170		0.16 (−0.63, 0.95); I^2 = 81%	Very low
	3–5 months	Back et al. (2019), Coffey et al. (2016), Ruglass et al. (2017)	3	205		0.09 (−0.28, 0.46); I^2 = 29%	Very low
	6–13 months	Back et al. (2019), Coffey et al. (2016), Mills et al. (2012)	3	256		0.01 (−0.35, 0.38); I^2 = 44%	Very low
Dropout		Back et al. (2019), Coffey et al. (2006, 2016), Foa et al. (2013), Sannibale et al. (2013)	5	459	0.86 (0.71, 1.04); I^2 = 48%		Very low
Adverse events		Back et al. (2019), Foa et al. (2013), Mills et al. (2012), Ruglass et al. (2017), Sannibale et al. (2013)	5	493	0.85 (0.40, 1.82); I^2 = 0%		Very low

(Continued)

Table 2. Continued.

Comparison outcome	Follow-up point	Contributing studies	Studies (n)	Sample (n)	RR (95% CI)	SMD (95% CI)	Grade rating
ICBT + TAU for SUD vs TAU for SUD only							
PTSD severity	Post-treatment	Capone et al. (2018), Haller et al. (2016), McGovern et al. (2011, 2015)	4	349		−0.24 (−0.51, 0.03); I^2 = 33%	Very low
	3–5 months	Capone et al. (2018), Haller et al. (2016), McGovern et al. (2011)	3	156		−0.12 (−0.44, 0.20); I^2 = 0%	Very low
	6–13 months	McGovern et al. (2011)	1	43		0.07 (0.94, 1.30)	Very low
PTSD diagnosis	Post-treatment	McGovern et al. (2011)	1	53	0.94 (0.68, 1.30)		Very low
Alcohol use	Post-treatment	Capone et al. (2018), Haller et al. (2016), McGovern et al. (2011, 2015)	4	352		0.02 (−0.19, 0.24); I^2 = 0	Very low
	3–5 months	Capone et al. (2018), Haller et al. (2016), McGovern et al. (2011)	3	165		−0.10 (−0.41, 0.21); I^2 = 0	Very low
	6–13 months	Haller et al. (2016)	1	75		0.19 (−0.27, 0.64)	Very low
Substance use	Post-treatment	Capone et al. (2018), Haller et al. (2016), McGovern et al. (2011, 2015)	4	352		−0.08 (−0.30, −0.13); I^2 = 0	Very low
	3–5 months	Capone et al. (2018), Haller et al. (2016), McGovern et al. (2011)	3	165		−0.01 (−0.31, 0.30); I^2 = 0	Very low
	6–13 months	Haller et al. (2016)	1	75		0.19 (−0.27, 0.64)	Very low
Web-based CBT + TAU vs TAU							
PTSD severity	Post-treatment	Acosta et al. (2017)	1	49		−0.07 (−0.63, 0.49)	Very low
	3–5 months	Acosta et al. (2017)	1	49		−0.29 (−0.85, 0.28)	Very low
Alcohol use	Post-treatment	Acosta et al. (2017)	1	61		0.11 (−0.39, 0.61)	Very low
	3–5 months	Acosta et al. (2017)	1	61		0.19 (−0.31, 0.69)	Very low
CBT for PTSD vs TAU only							
PTSD severity	Post-treatment	Mueser et al. (2008)	1	44		−0.22 (−0.83, 0.39)	Very low
	3–5 months	Mueser et al. (2008)	1	44		−0.25 (−0.86, 0.36)	Very low

CBT, cognitive behavioural therapy; CI, confidence interval; ICBT, integrated cognitive behavioural therapy; PTSD, post-traumatic stress disorder; RR, relative risk; SMD, standardized mean difference.
RR (of categorical data): RR = 1, same as control; RR < 1, intervention better; RR > 1, control better.
SMD (of continuous symptom score): SMD = 0, no difference between intervention and control; SMD < 0, intervention better; SMD > 0, control better.
*Statistically significant difference at the $p < 0.05$ level.

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Roberts et al. (2023)

Roberts, Lotzin & Schäffer (2023) provide a summary of expert recommendations based on their 2022 meta-analysis findings. Yet

Commenter (Group or Individual?)	Section	Comment	Panel Response
		the CPG does not cite Roberts et al. (2023) and does not align with the points below. Roberts, N. P., Lotzin, A., & Schäfer, I. (2023). Psychological treatment of PTSD with comorbid substance use disorder (SUD): expert recommendations of the European Society for Traumatic Stress Studies (ESTSS). *European Journal of Psychotraumatology*, *14*(2), 2265773. https://www.tandfonline.com/doi/10.1080/20008066.2023.2265773?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed#d1e305 **Seeking Safety** • "Current evidence for adults is that present focused therapies such as Seeking Safety are not more effective than SUD only treatments at improving PTSD symptoms. However, there is evidence that present focused treatment and treatment for SUD-only demonstrate small to medium improvements in PTSD and SUD symptoms. In the absence of access to trauma focused psychological intervention these interventions may therefore be of benefit to some individuals with PTSD-SUD comorbidity." [pg. 6] *They don't recommend against Seeking Safety and indeed state potential benefits.* **TFTs** The CPG [pg. 26] states:	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		○ When a patient presents with PTSD as the primary diagnosis along with a substance use disorder, providers are encouraged not to delay implementing an evidence-based treatment for PTSD (Roberts et al., 2022), in the absence of a clear clinical contraindication, such as the need for acute detoxification, and with the caveat that the clinician has appropriate substance-focused training, clinical supervision, or is working in the context of a team specializing in substance use disorders. • The above erroneously cites Roberts et al. (2022) in the first sentence; that is not in the article. Roberts et al. (2022) only state [on their pg. 3] that *the VA/DOD Treatment Guidelines "recommended that the presence of comorbidity should not prevent patients from receiving other guideline recommended interventions (VA/DoD, 2017)"* [note too that even this quote in Roberts doesn't mention "delay"]. • Most importantly, the CPG statement highlighted in orange above is too strongly worded. It is clinically unsound and goes far beyond the evidence in Roberts et al. (2022) and the "very low quality" SOE of the current literature on TFTs for PTSD/SUD, as summarized earlier in this letter. • Roberts et al. (2023) are much more circumspect in their recommendations than the CPG: o "Readiness to engage in evidence-based treatment should be evaluated on an individual basis." [pg. 5]	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		o "Current evidence for adults is that those receiving combined and integrated PTSD SUD treatment make similar progress to those receiving SUD only based interventions in reducing drug and alcohol use." [pg. 6] o "Patients presenting with co-occurring PTSD-SUD should be offered integrated treatment or evidence-based treatment for PTSD without waiting for abstinence. However, the trauma focused component of treatment should not commence until the individual demonstrates the capacity to manage treatment related distress without recourse to prolonged, therapy interfering substance misuse. Decisions about readiness to begin trauma focused intervention should be undertaken collaboratively and some planning for the management of cravings related to exposure related reminders should be undertaken before the onset of trauma processing." [pg. 6]. o "[For TFTs] average treatment gains are smaller than they are for individuals without SUD comorbidity and there is a higher level of treatment dropout." [pg. 6.]. See also the next section in this letter, which offers language from Hien et al. (2023) for a balanced representation of clinical advice based on current PTSD/SUD treatment evidence. The articles below are not part of the CPG, which is understandable due to the need to rely on a limited number of reviews. However I'm listing them here as they offer additional support for the idea that the area of PTSD/SUD treatment is in flux and remains at a	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		early stage with different conclusions depending on the analysis. (In contrast the PTSD-alone field is much more mature with many more high quality studies and a more consistent set of findings.) This is all the more reason for the CPG to temper its over-enthusiastic rating for TFTs for PTSD/SUD. ***Hien et al. (2023)*** Hien, D. A., Morgan-López, A. A., Saavedra, L. M., Ruglass, L. M., Ye, A., López-Castro, T., … Back, S. E. (2023). Project Harmony: A Meta-Analysis With Individual Patient Data on Behavioral and Pharmacologic Trials for Comorbid Posttraumatic Stress and Alcohol or Other Drug Use Disorders. American Journal of Psychiatry, 180(2), 155–166. https://doi.org/10.1176/appi.ajp.22010071 https://psychiatryonline.org/doi/full/10.1176/appi.ajp.22010071 • An example from Hien et al. (2023): their Table 2 indicates that SUD behavioral treatments and even TAU per se had a larger effect size for PTSD than TFTs at end of treatment. Moreover TFTs in the absence of medication did not outperform TAU and placebo medication. • They provide a balanced view of TFTs in light of public health goals: "…when feasible, integrated trauma-focused treatments should be made available to patients with PTSD + AOD. However, these treatments require resources that may not be available in all settings (e.g., to train staff, to have adequate staff to schedule	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		individual psychotherapy sessions that are sometimes as long as 90 min). Also, trauma-focused techniques may require more training and expense and may not readily be conducted in AOD treatment settings where individual therapy is rarer, and group models are the norm (day programs, residential). In contrast, AOD-only and nontrauma-focused achieve smaller effects for PTSD than trauma-focused treatments, but may be less complex, less costly, and can be delivered in a group format, which are likely more appealing and feasible for the general workforce. Moreover, not all patients are good candidates for trauma-focused treatment, such as those with no or insufficient memory of the trauma due to serious injury or loss of consciousness during the event or the early age of the trauma. Other treatment options such as AOD-only or non-trauma-focused psychotherapies, which may produce less change in PTSD symptoms than trauma-focused treatments but still lead to clinical improvement, are viable options for clients who do not want trauma-focused treatments or are not able to access them." [pg. 29] ***Simpson et al. (2021)*** Simpson, T. L., Goldberg, S. B., Louden, D. K., Blakey, S. M., Hawn, S. E., Lott, A., ... & Kaysen, D. (2021). Efficacy and acceptability of interventions for co-occurring PTSD and SUD: A meta-analysis. *Journal of Anxiety Disorders*, *84*, 102490. https://www.sciencedirect.com/science/article/pii/S0887618521001377 • All active treatments reduced PTSD and substance use disorder (SUD) outcomes. [pg. 1].	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• Neither TFTs nor non-TFTs outperformed manualized SUD treatments on PTSD outcomes at either time point. [pg. 1]. • "The current meta-analysis largely affirms the idea that there is "no wrong door" when it comes to treatment options for individuals with PTSD/SUD (see Simpson et al., 2017). Specifically, we found evidence that trauma-focused, non-trauma-focused, manualized SUD treatments, and SUD TAU are all associated with significant improvements on both PTSD and SUD outcomes. Between-group differences were less consistent and much less robust. Trauma-focused treatments showed slight indications of advantage relative to all comparators regarding PTSD outcomes although manualized SUD treatments also showed slight indications of advantage relative to trauma-focused and non-trauma-focused treatments regarding SUD outcomes. These findings have important public health implications…" [pgs. 11]. "The central finding of this meta-analysis of behavioral RCTs for people with PTSD/SUD is that while there were medium to large within-group effects for all who received some form of treatment, between-group effects were generally small and non-significant. Although these findings may be surprising to some and are generally contrary to received wisdom… we believe the findings are potentially positive from a public health standpoint. Consistent with the larger psychotherapy literature… the present findings suggest that when people with PTSD and SUD have access to *bona fide* treatments (i.e., with a cogent rationale and intended to be therapeutic; Wampold et al., 1997), they generally improve on both aspects of their comorbidity and further and that the specific type of care may not be especially consequential. Indeed, the finding	

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		that manualized SUD treatments were not inferior to trauma-focused nor non-trauma-focused treatments on either PTSD or SUD outcomes and showed modest advantages over both in two between-group models suggests that individuals with this comorbidity may address their mental health challenges with treatments that may be more accessible." [pgs. 10-11]. **Hien et al. (2023; APPENDIX)** Hien, D. A., Morgan-López, A. A., Saavedra, L. M., Ruglass, L. M., Ye, A., López-Castro, T., … Back, S. E. (2023). Project Harmony: A Meta-Analysis With Individual Patient Data on Behavioral and Pharmacologic Trials for Comorbid Posttraumatic Stress and Alcohol or Other Drug Use Disorders. American Journal of Psychiatry, 180(2), 155–166. https://doi.org/10.1176/appi.ajp.22010071 https://psychiatryonline.org/doi/full/10.1176/appi.ajp.22010071 Results below are highlighted in yellow for psychological models relevant to this letter (integrated TFTs, SUD-only interventions, and TAU). In blue highlight is placebo medication. • **TABLE 2**. Comparative effect sizes for eight treatment classifications (with treatment as usual as the comparator) on PTSD and severity of alcohol or drug use outcomes at end of treatment and 12 months posttreatment[a] [pgs. 160-161]	

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	PTSD				Alcohol Use				Drug Use			
	End of Treatment		12 Months Posttreatment		End of Treatment		12 Months Posttreatment		End of Treatment		12 Months Posttreatment	
Treatment	d	95% CI	d	95% CI	d	95% CI	d	95% CI	d	95% CI	d	95% CI
Trauma-focused therapy and pharmacotherapy for alcohol or other drug use	−0.92[b]	−1.57, −0.30	−2.00[b]	−3.38, −0.68	−1.10[b]	−1.54, −0.68	−1.24[b]	−2.03, −0.40	n.s.	n.s.	−0.27[c]	−1.07, 0.53
Trauma-focused nonintegrated behavioral therapy	−0.24[c]	−0.50, 0.01	−0.46[b]	−0.93, −0.04	−0.45[b]	−0.64, −0.26	−0.24[c]	−0.51, 0.03	n.s.	n.s.	n.s.	n.s.
Trauma-focused integrated behavioral therapy	−0.47[b]	−0.94, −0.01	n.s.	n.s.	−0.42[b]	−0.74, −0.10	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
Pharmacotherapy for alcohol or other drug use	−0.41[b]	−0.77, −0.08	−1.37[b]	−2.15, −0.63	−0.83[b]	−1.07, −0.60	−0.84[b]	−1.30, −0.41	n.s.	n.s.	−0.31[c]	−0.79, 0.11

	PTSD				Alcohol Use				Drug Use			
	End of Treatment		12 Months Posttreatment		End of Treatment		12 Months Posttreatment		End of Treatment		12 Months Posttreatment	
Treatment	d	95% CI	d	95% CI	d	95% CI	d	95% CI	d	95% CI	d	95% CI
Placebo medication	−0.32[b]	−0.53, −0.12	−0.57[b]	−1.08, −0.01	−0.47[b]	−0.64, −0.31	−0.29[b]	−0.65, −0.09	n.s.	n.s.	n.s.	n.s.
Behavioral intervention for alcohol or other drug use	−0.60[b]	−0.80, −0.38	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
Non-trauma-focused integrated behavioral therapy	n.s.	n.s.	−0.22[c]	−0.54, 0.09	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
PTSD pharmacotherapy	−0.41[c]	−0.79, 0.24	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	0.82[d]	−1.20, 2.99
Treatment as usual[a]	−0.61	−0.72, −0.52	−1.16	−1.40, −0.92	−0.37	−0.44, −0.30	−0.36	−0.50, −0.22	−0.53	−0.61, −0.47	−0.63	−0.78, −0.47

Simpson et al. (2021; APPENDIX)

- *3.5. Synthesis of results* Within-group effects across the five treatment and control conditions are displayed in Table 2 and

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		Fig. 2. All five types of conditions were associated with statistically significant small to large magnitude reductions in PTSD and SUD symptoms, both at post-treatment and follow-up. Heterogeneity was high across almost all within-group models (I2 > 75%). Between-group effects on PTSD and SUD outcomes as well as treatment completion are displayed in Tables 3 and 4 and Fig. 3. In general, these models indicated small magnitude differences that were not statistically significant between both trauma-focused and non-trauma-focused treatments when each was compared with all comparators and with manualized SUD treatments, with some exceptions described below. Trauma-focused treatments showed significantly larger effects on PTSD at post-treatment (*g* = 0.29, [0.07, 0.52]) than all comparators, but this difference did not carry through to follow-up. Trauma-focused treatments did not differ from all comparison types on measures of SUD at post-treatment or follow-up. When trauma-focused treatments were compared with manualized SUD treatments there were no significant differences on PTSD at post-treatment or follow-up. Trauma-focused treatments showed significantly smaller effects on SUD symptoms than manualized SUD treatments at post-treatment (*g* = □ 0.27, [□ 0.48, □ 0.06]), but this difference did not persist to follow-up (*g* = □ 0.21, [□ 0.47, 0.04]). Trauma-focused treatments did not differ significantly from all comparators (OR = 0.85, [0.60, 1.21]) or manualized SUD treatments (OR = 0.92, [0.63, 1.36]; Table 4) on treatment completion. Sensitivity analyses revealed that none of the patterns in the between-group models changed when the two studies comparing trauma-focused and non-trauma-focused	

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		treatments (Najavits et al., 2018; Norman et al., 2019) were included. Similarly, the between-group patterns pertaining to trauma-focused vs. manualized SUD treatments were unchanged when only the five studies involving empirically supported PTSD treatments were considered (Back et al., 2019; Foa et al., 2013; Ruglass et al., 2017; Simpson et al., 2021; Vujanovic, personal communication).” [pgs. 5-6]. • “All within-group models showed significant effects, mostly in the moderate to large range, for both PTSD and SUD outcomes at follow-up. This pattern of results indicates that across both experimental (i.e., trauma-focused and non-trauma-focused treatments) and control conditions, participants in these studies generally improved on both primary outcomes. Within-group models show that trauma-focused and manualized SUD treatments were mostly associated with large effect sizes for both PTSD and SUD outcomes (*g*s = 0.80–1.11), while SUD TAU and non-trauma-focused treatments showed small to large effects (*g*s = 0.30–0.79). No/minimal treatment conditions were associated with small to large effects (*g*s = 0.49–1.29), though the large effects were based on the sole study with follow-up data wherein nearly all control participants were in SUD treatment (Mills et al., 2012). Of note, within-group results appeared robust on publication bias (trim-and-fill), FSN).” [pg. 8]. • “we found that when compared with all types of comparators, trauma-focused treatments showed a small advantage for	

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		reductions in PTSD severity at post-treatment assessment (*g* = 0.29), though the advantage did not persist to the longest follow-up and was not robust to publication bias corrections. We also found that trauma-focused treatments did not out-perform all other comparators on SUD outcomes at either immediate or longest follow-up." [pg. 10]. • "When we restricted the models to studies involving a manualized SUD treatment, not only did the post-treatment advantage for trauma-focused interventions for PTSD outcomes disappear, but the immediate post-treatment model regarding SUD outcomes indicated a small advantage for manualized SUD treatments (*g* = 0.27). Thus, when compared with trauma-focused interventions, manualized SUD treatments did not differ significantly regarding PTSD outcomes and performed somewhat better on early SUD outcomes, a pattern of findings that held up in our sensitivity analyses including only studies using trauma-focused treatments based on empirically supported PTSD interventions. [pg. 10].	

Commenter (Group or Individual?)	Section	Comment	Panel Response
Lisa M. Najavits, PhD (Individual)	Processes and Methods for the CPG	Hoffman V, Middleton JC, Feltner C, Gaynes BN, Weber RP, Bann C, Viswanathan M, Lohr KN, Baker C, Green J. Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder: A Systematic Review Update. Comparative Effectiveness Review No. 207. (Prepared by the RTI International-University of North Carolina at Chapel Hill Evidence-based Practice Center under Contract No. 290-2015-00011-I for AHRQ and PCORI.) AHRQ Publication No. 18-EHC011-EF. PCORI Publication No. 2018-SR-01. Rockville, MD: Agency for Healthcare Research and Quality; May 2018. DOI: https://doi.org/10.23970/AHRQEPCCER207. • The Hoffman et al. review was used in part for the Seeking Safety CPG rating but Hoffman et al.'s meta-analysis is six years old and appears to be superseded by Roberts et al. (2022). Hoffman et al. had fewer studies to rely on and was unable to conduct a meta-analysis on Seeking Safety ("meta-analysis not performed because of heterogeneity in sample and study characteristics, low SOE for no difference"). [Pg. 89, Hoffman et al., 2018]. Also none of the other PTSD/SUD models covered in the CPG rely on Hoffman et al. *It's not clear why Hoffman et al. is included in the CPG, given the above.*	Thank you for your comment. The original Hoffman et al. review was supplemented by an additional 14 reviews in order to address the scope of the panel's focus as well as ensure recency of the data. After reviewing your feedback, the panel re-visited its recommendation about Seeking Safety, re-examined the data and voted to change the recommendation as noted: **Level**: Other Treatments Reviewed **Recommendation Statement**: For patients with PTSD and comorbid SUD [substance use disorder], evidence indicates **no difference in effect** on PTSD symptoms or substance use for the following interventions **over a TAU for SUD intervention**. Thus, the panel makes **no recommendation** for or against the following interventions listed: ❖ Seeking Safety ❖ Seeking Safety plus TAU **Strength/Direction**: No difference in effect **Rationale**: Findings indicate no difference in effect for critical outcomes, no information or unclear effect on important outcomes. There

Commenter (Group or Individual?)	Section	Comment	Panel Response
			was no evidence of differential harms/burdens although there is variability in the TAU category. The balance of benefits to harms/burdens is the same for seeking safety as control.
Lisa M. Najavits, PhD (Individual)	General Comment	**Context factors re Seeking Safety** One of the known challenges of the CPG is that, due to its methodology, various clinically-relevant factors are not addressed. But it would be useful to explicitly state the importance of these and the fact that they do impact RCT results. I list some here to consider. **Seeking Safety** • Boden et al. (2012) pg. 585 state: "SS simultaneously addresses PTSD early within SUD treatment, is appealing to [patients] and staff, and uses techniques familiar to the majority of addiction treatment professionals, which may • Furthermore, compared to other evidence-based treatments for PTSD (e.g. cognitive processing therapy), SS is less costly in terms of requirements for training, supervision and consultation, which may also increase feasibility of use." • As Roberts et al. (2022) identified, Seeking Safety has been studied almost exclusively in group modality whereas TFTs were all studied in individual modality. It is easier to achieve positive results in individual than group modality (a known finding in the PTSD field).	Thank you for your comment. The panel worked to address many of these clinically relevant contextual factors in the Implementation Considerations section as well as worked to highlight limitations of the approach and future directions for research in the Recommendations for Research and Discussion sections of the document. This information will be added more broadly within the document. After reviewing your feedback, the panel re-visited its recommendation about Seeking Safety, re-examined the data and voted to change the recommendation as noted: **Level**: Other Treatments Reviewed **Recommendation Statement**: For patients with PTSD and comorbid SUD [substance use disorder], evidence indicates **no difference in effect** on PTSD symptoms or substance use for the following interventions **over a TAU for SUD intervention**. Thus, the panel makes **no**

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		• Inclusion/exclusion criteria were more restricted in TFT studies for PTSD/SUD (healthier patients) than in Seeking Safety studies (Najavits, Clark, DiClemente, Potenza, Shaffer, Sorensen et al., 2020). • Seeking Safety studies does not have the intensive selection/training/supervision requirements for study therapists compared to TFT studies. Moreover, in two studies in Roberts et al., 2022, even basic Seeking Safety training and fidelity standards were not met and Seeking Safety was adapted without permission or consultation (Norman et al., 2019, and Myers et al. 2015; see Najavits, 2019). Myers et al. (2015) was an unpublished, non-peer reviewed study that was never completed. • Per Roberts et al. (2022) the number of Seeking Safety sessions ranged from eight to 25 sessions, which meant highly variable impact. • Two studies in Roberts et al. ended recruitment early so had power limitations (Myers et al., 2015; Boden et al., 2012). And Zlotnick et al. (2009) had no end-of-treatment assessment; no blind assessments at all; and a mandatory dose of TAU that was very large compared to the voluntary Seeking Safety dose. • Two Seeking Safety studies were effectiveness rather than efficacy studies (Hien et al., 2009 and Boden et al., 2018). • Hien et al. (2009): (i) allowed patients in both study conditions to be in trauma-focused or other trauma-specific treatments during the study, but did not measure or account for this in the data analyses; (ii) had a large proportion of patients who were either abstinent from	**recommendation** for or against the following interventions listed: ❖ Seeking Safety ❖ Seeking Safety plus TAU **Strength/Direction**: No difference in effect **Rationale**: Findings indicate no difference in effect for critical outcomes, no information or unclear effect on important outcomes. There was no evidence of differential harms/burdens although there is variability in the TAU category. The balance of benefits to harms/burdens is the same for seeking safety as control.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		substances at baseline or had very low levels of use (an average of 1 day in the prior month), which meant it was not adequately powered for SUD outcomes. • Boden et al. (2014): an inclusion criterion for Seeking Safety participants was current PTSD but this was not required for TAU comparison condition participants. *All studies have limitations; and both Roberts et al. (2022) and Hoffman et al. (2018) used what they had available and described their methodology clearly. But for the CPG to recommend against use of a model (whether Seeking Safety or any other) would require a larger number of studies and more consistency and higher-grade studies.* *Note too that the Seeking Safety website has a large number of published studies, most by independent teams; and although most do not fit criteria for inclusion in meta-analyses, they consistently show significant impact on PTSD and/or SUD, and implementation studies show it to be highly adopted and sustained over time. For example:* The Hien et al. 2009 National Institute on Drug Abuse clinical trials network study found Seeking Safety superior to the comparison condition on various secondary outcomes including: among alcohol users (Hien, Campbell, Ruglass et al., 2010); substance use among heavy drug users (Hien, Jiang et al., 2010); in therapeutic alliance (Ruglass et al., 2012); and in HIV risk reduction (Hien, Campbell, Killeen, et al., 2010). An implementation/adoption study by Los Angeles County Department of Mental Health surveyed 59 agencies and found Seeking Safety the second most adopted of 6 models, and sustained by 83% of agencies that adopted it (Rodriguez et al., 2018).	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		A recent systematic review by Johnstone et al. (2023) (24 studies totaling over 3000 patients) addressed 10 gender-based treatments for SUD and found Seeking Safety was one of only three models to outperform comparison conditions on SUD and mental health outcomes. • The CPG pg. 35 (orange highlight below) states the need to address safety and stabilization for C-PTSD but this is not addressed in the PTSD/SUD section, even though PTSD/SUD patients have high rates of C-PTSD. Seeking Safety has been studied primarily in C-PTSD samples (Najavits & Hien, 2013). The diagnosis of C-PTSD may pose special clinical challenges such as incorporating safety and stabilization techniques, and other methods tailored to address the distinct symptoms and complexities associated with complex PTSD (National Center for PTSD, 2022). In both *Overall, the CPG relies on IOM criteria, which were not developed for psychological treatments and do not take into account many of the context factors named above.*	
Lisa M. Najavits, PhD (Individual)	General Comment	**Small errors in the CPG in need of correction** ***CPG Draft*** • Pg. 21 lists "COPE + TAU vs. Seeking Safety" but Seeking Safety also had TAU so it should read: "COPE + TAU vs. Seeking Safety + TAU" • Pg. 23 lists "Seeking Safety + TAU for SUD"; as noted earlier this is inaccurate (it relates to a discrepancy in Roberts et al., 2022, Tables 1 and 2; moreover if you look at the actual studies they are almost all TAU not SUD TAU); in the CPG it should thus read "Seeking Safety + TAU." • Pg. 153: please change the description and citation for Creating Change as they are not accurate. The description could be: "A manualized trauma-focused cognitive-behavioral model for trauma	Thank you for catching and noting these. These edits are being made to the document and a footnote in the guideline as well as a note in brackets will be inserted in Appendix J noting the discrepancies in Roberts et al's (2022) Table 1 and Table 2 headings. As for the "Seeking Safety + TAU for SUD" requested edit, the Panel further reviewed the studies identified within Roberts et al (2022)

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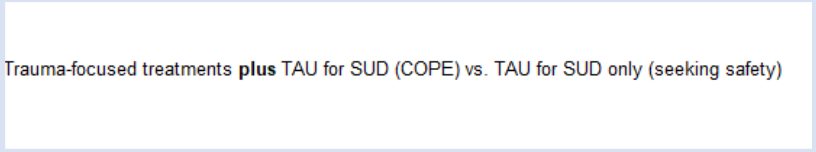
		and/or addiction. By the developer of Seeking Safety, it has the same style and format as Seeking Safety, but focuses on the past instead of the present (Najavits, 2024)." Also please update the citation to: "Najavits, LM (2024). Creating Change: A past-focused treatment for trauma and addiction. New York: The Guilford Press." • Pg. 154: the description of Seeking Safety also has some issues. A description could be: "A present-focused, manualized cognitive-behavioral model that teaches coping skills to help patients with trauma and/or addiction attain greater safety in their life." ***Appendix Grid*** • Column AO incorrectly identifies Seeking Safety as "TAU" although Seeking Safety is a manualized active comparison treatment in this study. Column AO:  Trauma-focused treatments **plus** TAU for SUD (COPE) vs. TAU for SUD only (seeking safety) • CPG Appendix Grid rows 59 and 106, column AN, acknowledge weaknesses for TFT results for PTSD/SUD but appear to be portraying the results as better than they are. Also row 112 appears overly positive and strong than is warranted by row 59.	and concluded that the "plus TAU for SUD" modifier was the most accurate representation of the included studies. Most of the studies (i.e., 5 of 6) were either TAU for SUD (n=4) or relapse prevention (n=2). Three of the six identified studies were Seeking Safety + TAU for SUD and two studies were Seeking Safety combined with TAU (not for SUD specifically).
Lisa M. Najavits, PhD (Individual)	General Comment	**Possible conflict of interest** The CPG has a clear, understandable, and detailed COI policy. However, on pg. 106 it states:	Thank you for taking the time to consider and provide this feedback. You raise important points. We will share this feedback with the Advisory Steering Committee that oversees APA's development of clinical practice guidelines to consider clarifying the first bullet

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• "While intellectual affiliations were expected, no panel members had been singularly identified with particular approaches to intervention." • "Conflicts of interest included not only possibilities for financial or professional gain but also strong intellectual viewpoints that might then limit someone from objectively reviewing the evidence." *The chair and co-chair are (based on their CVs) focused throughout their career on TFTs for PTSD so the first bullet point above does not appear entirely accurate. It's understood that COI may exist but their intellectual affiliations with TFTs should perhaps be declared more explicitly.*	point. Further, a note summarizing this point will be added to the author's disclosures summary for the chair and vice-chair.
Lisa M. Najavits, PhD (Individual)	General Comment	**Expertise** None of the panel members are known to be national experts in PTSD/SUD treatment research. It's understandable that not every domain in the CPG will be represented by a specific panel member. However, the PTSD/SUD section of the CPG may be impacted by this. **Closing** I know the CPG committee is committed to positive impact on the field. I hope the committee will carefully reconsider its rating of Seeking Safety, as well as other PTSD/SUD models covered in the CPG, so as to accurately reflect current knowledge (and knowledge gaps) with regard to PTSD/SUD psychological treatments. **References** *See also references and URLs listed above for articles described in detail in this letter (those references are not repeated below).*	Thank you for your comment. While it is not feasible to have every possible domain represented by a panel member as you note, it is hoped that the breadth of expertise of the panel members will cover many areas, and that feedback received during public comment periods from experts with specialized knowledge in certain areas such as yourself will help to optimally shape this document and recommendations. Several members of the panel have clinical experience treating substance use disorders and PTSD and/or being involved in clinical trials for this comorbidity. Thank you again for taking the time to provide such careful and thoughtful feedback on this

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Hien, D. A., Campbell, A. N., Ruglass, L. M., Hu, M. C., & Killeen, T. (2010). The role of alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's Women and Trauma Study. *Drug and Alcohol Dependence*, *111*(1-2), 114-119. Hien, D. A., Campbell, A. N., Killeen, T., Hu, M. C., Hansen, C., Jiang, H., ... & Nunes, E. V. (2010). The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA clinical trials network "women and trauma" multi-site study. *AIDS and Behavior*, *14*, 421-430. Hien, D. A., Jiang, H., Campbell, A. N., Hu, M. C., Miele, G. M., Cohen, L. R., ... & Nunes, E. V. (2010). Do treatment improvements in PTSD severity affect substance use outcomes? A secondary analysis from a randomized clinical trial in NIDA's Clinical Trials Network. *American Journal of Psychiatry*, *167*(1), 95-101. Johnstone, S., Dela Cruz, G. A., Kalb, N., Tyagi, S. V., Potenza, M. N., George, T. P., & Castle, D. J. (2023). A systematic review of gender-responsive and integrated substance use disorder treatment programs for women with co-occurring disorders. *The American Journal of Drug and Alcohol Abuse*, *49*(1), 21-42. Najavits, L. M. (2019). Comment on Norman et al. Concerns about potential bias in a randomized clinical trial of integrated prolonged exposure therapy vs Seeking Safety integrated coping skills therapy—reply. *JAMA Psychiatry.* doi:10.1001/jamapsychiatry.2019.2229 Najavits, L. M., Clark, H. W., DiClemente, C. C., Potenza, M. N., Shaffer, H. J., Sorensen, J. L., Tull, M. T., Zweben, A., Zweben, J. E. (2020). PTSD /	document and recommendations. It is feedback from caring and concerned individuals such as yourself that helps to improve this product to make a more positive impact on the field. And as noted above, your very helpful feedback resulted in the panel reconsidering and changing its recommendation on Seeking Safety.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		substance use disorder comorbidity: Treatment options and public health needs. *Current Treatment Options in Psychiatry,* 1-15. Najavits, L. M., & Hien, D. (2013). Helping vulnerable populations: A comprehensive review of the treatment outcome literature on substance use disorder and PTSD. *Journal of clinical psychology*, *69*(5), 433-479. Rodriguez, A., Lau, A. S., Wright, B., Regan, J., & Brookman-Frazee, L. (2018). Mixed-method analysis of program leader perspectives on the sustainment of multiple child evidence-based practices in a system-driven implementation. *Implementation Science*, *13*, 1-14. Ruglass, L. M., Miele, G. M., Hien, D. A., Campbell, A. N., Hu, M. C., Caldeira, N., ... & Nunes, E. V. (2012). Helping alliance, retention, and treatment outcomes: A secondary analysis from the NIDA clinical trials network women and trauma study. *Substance Use & Misuse*, *47*(6), 695-707.	

Section 3: Trauma-Sensitive Yoga

PANEL RESPONSE:

Thank you for your comments. With regard to van de Kamp (2023), the GUP incorporated this systematic review specifically to consider mind-body interventions for PTSD. These interventions included trauma-focused yoga. Many of the papers referred to by commentators (below) were included in van de Kamp's (2023) review.

With regard to individual RCTs referred to by commentators it should be noted that APA's guideline development process does not select and review individual studies of psychological interventions. The APA's guideline development process follows IOM's (2011 a, b) standards, a vetted and evidence-based guideline development methodology that relies on systematic reviews in order to reduce bias. However, there are a few exceptions with factors that are part of the decision-making process about recommendations; when considering harms and burdens and patients values and preferences, a broader inclusion of literature (e.g., observational) and clinician and patient expertise and experience is invited. Furthermore, all systematic reviews must also meet AMSTAR (Shea et al 2017) or AHRQ or Cochrane quality criteria While IOM guidance suggest one or more, but the fewest possible, high-quality systematic reviews be used in guideline development, nonetheless the GUP considered fifteen (15) reviews. The GUP stretched to this extent to consider the broadest range possible of interventions of interest to clinicians and clients.

The guideline development process is a vetted, evidence-based process (Institute of Medicine, 2011a); reliable treatment recommendations are based on aggregated data from repeated, well-conducted trials of specific interventions. Individual trials, while necessary and important, are insufficient to make a recommendation. Evidence for the utility of the specific trauma-focused yoga intervention, while encouraging, was insufficient. A conclusion of "insufficient evidence" does not imply ineffectiveness, however, it is not within the Panel's standards and process to make a stronger, or more definitive, recommendation at this time. Based on the IOM standards for CPG development, in order to be recommended, a treatment must have a certain level and kind of quantitative research supporting it with strong efficacy. If a treatment is not included among the recommended or suggested treatments, this does not necessarily mean that it doesn't work. Rather, there was not enough specific research that met the IOM criteria.

Most GUP members are experienced clinicians, and we agree that psychological treatments, including PTSD treatment, must consider each individual patient's needs, preferences, and individual characteristics as part of evidence-based practice. Evidence for the role of yoga in the recovery from PTSD is growing. We encourage you and others to continue pursuing and publishing high-quality research on yoga's impact, as a stand-alone intervention or an augment to other PTSD treatments, in helping patients recover from PTSD. Additional research, specifically on TCTSY, is also needed.

The field of PTSD treatment is dynamic; clinical practice guidelines, therefore, are updated regularly to consider new developments and to reconsider previous recommendations based on new research.

Commenter (Group or Individual?)	Section	Comment	Panel Response
David Emerson (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH: the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention: Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to. We are asking that the panel consider TCTSY as a distinct model of care and not as part of the general category "trauma informed yoga". With the reseach record specifically associated with TCTSY, we think it warrants the recognition of APA and the	Thank you for your feedback. Please see the response on this topic above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		subsequent exposure that such a recognition would lead to. People with PTSD need to know that this is a validated option for them.	
David Emerson (Individual)	Appendix J	On behalf of the specific trauma informed yoga model called Trauma Center Trauma Sensitive Yoga (TCTSY) I would like to submit the following two RCTs that indicate a clinically significant loss of diagnosis and PTSD symptom reduction across groups Link and Link	Thank you for your feedback. Please see the response on this topic above.
Kim Tompkins (Individual)	Treatment Recommendations	I am a master's level LMHC and somatic psychotherapist working in MA who began training in trauma sensitive yoga through the Center for Trauma and Embodiment in 2012. Since then, I have seen vast improvements in trauma symptoms amongst a majority of my clients who have practiced TCTSY with me in groups or in private counseling. The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH: the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention: Link	Thank you for your feedback Please see the response on this topic above.

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		We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to. Best regards, Kim Tompkins, LMHC, BC-DMT, TCTSY-F	
Wyatt Kanyer (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention: Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY	Thank you for your feedback. Please see the response on this topic above.

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		stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Heather Keenan (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link. We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY	Thank you for your feedback Please see the response on this topic above.

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		stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Rachel Slough-Johnson (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: Link) and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	Thank you for your feedback Please see the response on this topic above.
Michelle Vande Hey (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category	Thank you for your feedback Please see the response on this topic above.

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		of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH: the first grant given by NIH to study yoga for trauma: Link ; and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Jamie White (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along	Thank you for your feedback. Please see the response on this topic above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH: the first grant given by NIH to study yoga for trauma: Link ; and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Kelsey Dietrich (Individual)	Treatment Recommendations	Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here: Link) there are two, strong RCTs. The first, published in 2014, funded by NIH NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes that were similar to CPT with notably higher retention rates for TCTSY Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as	Thank you for your feedback. Please see the response on this topic above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to. The empirically-supported model of TCTSY has the evidence to support its addition to be added to the APA treatments for PTSD which will increase the options of trauma care for individuals who are suffering. The higher drop out rates found with current APA-recommended PTSD treatment warrant additional options, such as TCTSY, to choose from. By adding TCTSY to this list, treatment-seeking individuals have another viable form of trauma care to seek.	
Laura Phoenix (Individua)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for	Thank you for your feedback. Please see the response on this topic above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Polly Weiss (Individual)	Treatment Recommendations	As noted in the Draft Guidelines, the 2023 Zaccari et al RCT indicates that Trauma Center Trauma-Sensitive Yoga (TCTSY), is a promising intervention for treatment of PTSD. As such, I am asking the Committee to consider TCTSY as an evidence-based treatment that is distinct from the general category of "trauma informed yoga. The TCTSY protocol is supported by strong evidence, has very low risk of harm, can be tailored to meet patient values and preferences not otherwise met by other types of treatment options, and is broadly accessible and affordable. Although the Draft Guidelines state that there is insufficient evidence for the Panel to recommend for or against general body- and movement-oriented interventions for patients living with PTSD, I believe there is ample evidence to conditionally recommend TCTSY specifically as an effective second-line treatment option.	Thank you for your feedback. Please see the response on this topic above.
Evan Bodine (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD, but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here Link) there are two, strong RCTs. The first, published in 2014, funded by NIH-- the first grant given by NIH to study yoga for	Thank you for your feedback. Please see the response on this topic above.

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		trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link. We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Meg Griffith (Individual)	Treatment Recommendations	Sadly but not surprisingly, we continue to leave out a large segment of our population when considering mental health. As the wife of a veteran with PTSD, I have seen the "gold-standard" and other "effective" treatments fail and cause even more damage because they do not take into account the needs of the person. CBT and CPT specifically caused greater stress and backward progress. But because of the language in documents like these, other options are either considered useless or ignored completely. For instance, the committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first	Thank you for your feedback and for your family's service to our country. We are sorry to hear about your experience. Please see the response on this topic above. We agree that it is important to individualize treatment as part of evidence-based practice in psychology, integrating the best possible evidence with clinician expertise and the patient's individual preferences, values, and characteristics and strive to discuss this in the guideline document.

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		grant given by NIH to study yoga for trauma: Link) and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention (Link) We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to. Your choice of language regarding other forms of treatment and their possible uses with other approaches could encourage seeing the human behind the trauma and making choices that benefit the whole person. In this, there would be a greater chance of supporting each person's needs vs forcing all into a neat box while closing your eyes to those you miss.	
Karen Schwartz (Individual)	Treatment Recommendations	I am a social worker, TCTSY facilitator, certified yoga therapist and registered yoga teacher with more than 30 years of experience working clinically with individuals and groups in a wide variety of settings. I am writing to support of the inclusion of “Trauma Center Trauma Sensitive Yoga” or “TCTSY” as a Level 2 intervention. Unlike the more broad and less defined “yoga” or “trauma informed yoga,” TCTSY has been studied, has shown clinically significant improvements in a group setting comparable to Cognitive Processing Therapy, and provides a valuable addition to treatment options for those who could benefit from an approach that facilitates symptom reduction through body-oriented approaches. TCTSY is unlike trauma-informed yoga in that it is a clear, measurable, defined methodology which prioritizes active components of trauma recovery and provides	Thank you for your feedback. Please see the response on this topic above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		opportunities for clients to engage in transforming problematic and trauma-driven patterns toward recovery. I have had survivors tell me, "I can feel the trauma leaving my body," and attest that TCTSY helped them when every other intervention they tried fell short. TCTSY is a proven, invaluable clinical intervention that deserves APA recognition and support. Thank you very much.	
Nicole Nakamura (Individual)	Treatment Recommendations (Line 323)	I am a psychologist, a registered yoga teacher, and a Trauma Center Trauma Sensitive Yoga (TCTSY) facilitator and mentor. I am writing to support of the inclusion of “Trauma Center Trauma Sensitive Yoga” or “TCTSY” as a Level 2 intervention. Unlike the more broad and less defined “yoga” or “trauma informed yoga,” TCTSY has been studied, has shown clinically significant improvements in a group setting comparable to Cognitive Processing Therapy, and provides a valuable addition to treatment options for those who could benefit from an approach that facilitates symptom reduction through body-oriented approaches. TCTSY is unlike trauma-informed yoga in that it prioritizes active components of trauma recovery, providing opportunities for clients to engage in transforming problematic and trauma-driven patterns toward recovery. These components include shame into compassion, danger into flexibility and safety, dissociation into attunement and connection, helplessness into agency, mistrust into greater self-trust, and so on. As a provider additionally trained in Prolonged Exposure and CPT, my clinical experience has shown me that each client’s treatment can and should be specific, based on what they need in order to facilitate their recovery. I have seen the ways in which TCTSY can be part	Thank you for your feedback. Please see the response on this topic above.

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		of their recovery and would encourage the committee to consider it as a Level 2 intervention. Mahalo.	
Amy Day (Group: Amy Day, Inherent Wisdom, LLC)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	Thank you for your feedback. Please see the response on this topic above.
Megan Bona (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma	Thank you for your feedback. Please see the response on this topic above.

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		Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here Link) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: Link and the second, published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention Link We are asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to.	
Christine Du Mond (Individual)	Treatment Recommendations	The committee has recommended CPT as a first line intervention for PTSD but relegates "trauma informed yoga" to the category of not enough evidence. We agree if "trauma informed yoga" is aggregated - there are too many options and variables to make a conclusive recommendation. However, the model that we have been working on for over 20-years - Trauma Center Trauma Sensitive Yoga (TCTSY) - is very specific and well researched - including in direct comparison to CPT (please see below). Along with dozens of outcome measurements, feasibility and qualitative studies on TCTSY (most of which can be found here https://www.traumasensitiveyoga.com/research) there are two, strong RCTs. The first, published in 2014, funded by NIH (the first grant given by NIH to study yoga for trauma: https://pubmed.ncbi.nlm.nih.gov/25004196/ and the second,	Thank you for your feedback. Please see the response on this topic above.

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		published in 2023, actually compared TCTSY to CPT with favorable outcomes and higher retention https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812725 I am asking the committee to consider TCTSY specifically as a distinct intervention and not as part of the category "trauma informed yoga" more generally. We feel strongly that TCTSY stands out in terms of scientific rigor and has proven it's worth as a replicable, viable treatment option for PTSD and that more people should have the chance to avail themselves of it if they choose to. My consistent - daily teaching of TCTSY to women with PTSD/Complex Trauma at the Center for Trauma Recovery (c4tr.org) is a key healing modality for our clients. It is an imperative aspect of the work we do as a team
Andrea Kappas Mazzio (Individual)	Complementary and Integrative Health Interventions	Given the goal of the APA to address member needs, enhance society, and support high-quality clinical services, the mental and behavioral health field must support and integrate a comprehensive network of evidence-based practice that more broadly addresses the varied experiences, interests, and needs of a diverse community of individuals. This includes Trauma Center Trauma-Sensitive Yoga (TCTSY), an established modality with over two decades of growing, rigorous, and promising research. While not to be confused with the broader term “trauma-informed yoga,” which does not denote a specific model, TCTSY for the treatment of PTSD is an efficacious evidence-based treatment with demonstrated success in feasibility, replicability, integration within clinical settings, retention, and positive and sustained outcomes post-treatment (see here for example studies, https://www.traumasensitiveyoga.com/research). As indicated in the APA Clinical Practice Guideline for the Treatment	Thank you for your feedback. Please see the response on this topic above. We agree that it is important to individualize treatment as part of evidence-based practice in psychology, integrating the best possible evidence with clinician expertise and the patient’s individual preferences, values, and characteristics and strive to discuss this in the guideline document.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update, while grouping TCTSY within the broader context of body-and-movement-oriented therapies, including trauma-informed yoga and group-trauma-sensitive yoga, the variability is evident. However, TCTSY merits consideration as a standalone treatment with sufficient and burgeoning evidence based on rigorous methodology that balances the benefits to harms and burdens. Given the above, and as a TCTSY facilitator, social worker, and researcher, I am writing in request to re-evaluate the committee's recommendations and in support of incorporating, within clinical practice guidelines, TCTSY as a distinct intervention that holistically addresses the mind-body needs of individuals with experiences of PTSD and that mirrors the established body of empirical literature and clinical expertise on trauma.	
Andrea Kappas Mazzio (Individual)	Treatment Recommendations – Complementary and Integrative Health Interventions	Given the goal of the APA to address member needs, enhance society, and support high-quality clinical services, the mental and behavioral health field must support and integrate a comprehensive network of evidence-based practice that more broadly addresses the varied experiences, interests, and needs of a diverse community of individuals. This includes Trauma Center Trauma-Sensitive Yoga (TCTSY), an established modality with over two decades of growing, rigorous, and promising research. While not to be confused with the broader term “trauma-informed yoga,” which does not denote a specific model, TCTSY for the treatment of PTSD is an efficacious evidence-based treatment with demonstrated success in feasibility, replicability, integration within clinical settings, retention, and positive and sustained outcomes post-treatment (see here for example	Thank you for your feedback. Please see the response on this topic above. We agree that it is important to individualize treatment as part of evidence-based practice in psychology, integrating the best possible evidence with clinician expertise and the patient’s individual preferences, values, and characteristics and strive to discuss this in the guideline document.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		studies, https://www.traumasensitiveyoga.com/research). As indicated in the APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults – 2024 Update, while grouping TCTSY within the broader context of body-and-movement-oriented therapies, including trauma-informed yoga and group-trauma-sensitive yoga, the variability is evident. However, TCTSY merits consideration as a standalone treatment with sufficient and burgeoning evidence based on rigorous methodology that balances the benefits to harms and burdens. Given the above, and as a TCTSY facilitator, social worker, and researcher, I am writing in request to re-evaluate the committee's recommendations and in support of incorporating, within clinical practice guidelines, TCTSY as a distinct intervention that holistically addresses the mind-body needs of individuals with experiences of PTSD and that mirrors the established body of empirical literature and clinical expertise on trauma.	

Section 4: Emotional Freedom Techniques (EFT)

Commenter (Group or Individual?)	Section	Comment	Panel Response
Robert Schwartz (Group: The Association for Comprehensive Energy Psychology [ACEP])	Treatment Recommendations	Response to APA clinical guidelines for PTSD for adults: This is the official response of the Association for Comprehensive Energy Psychology (ACEP) to provide comments on the updated Clinical Practice Guideline for the Treatment of PTSD in Adults. ACEP is a non-profit association of over 1400 mental healthcare and allied healthcare professionals who use energy psychology methods that include Emotional Freedom Techniques (EFT) frequently referred to as "tapping". We have enormous concerns about the current approach taken in developing these guidelines, which undermines the potential for effective and diverse treatment options for PTSD. The research has shown that EFT is a highly effective treatment that often works more rapidly with similar or better outcomes compared to other gold standard treatments. The updated Clinical Practice Guideline for the Treatment of PTSD in Adults failed to include any of the research on EFT over the last 10 years. Meanwhile other approaches with far less research support were included for evaluation. This is must be corrected. EFT for PTSD has had at least 3 meta-analyses and systemic reviews • Sebastian, B., and Nelms, J. (2017). The effectiveness of emotional freedom techniques in the treatment of posttraumatic stress disorder: a meta-analysis.	Thank you for your comment. APA develops its clinical practice guidelines in accordance with best practices for guideline development set forth by the National Academy of Medicine (formerly Institute of Medicine, 2011a & b). The Panel used the Population, Interventions, Comparators, Outcome, Timing, and Settings (PICOTS) framework (a standard and systematic approach to conducting literature reviews across all fields of evidence-based medicine; Samson & Schoelles, 2012) to formulate the scope of its inquiry. Consistent with the Panel who developed the 2017 APA guidelines, the Guideline Update Panel set our population as adults with PTSD. While the systematic review conducted by the Agency for Healthcare Research and Quality (Hoffman et al., 2018) that served as the primary evidence base did include "energy psychology" in their literature searches, the authors were not able to find any studies that met their inclusion/exclusion criteria (i.e., PICOTS framework). At present, there are no systematic reviews of energy psychology approaches that meet our PICOTS. Specifically,

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Explore J. Sci. Heal. 13, 16–25. doi: 10.1016/j.explore.2016.10.001 • Stapleton, P., Kip, K., Church, D., Toussaint, L., Footman, J., Ballantyne, P., & O'Keefe, T. (2023). Emotional freedom techniques for treating post traumatic stress disorder: an updated systematic review and meta-analysis. Frontiers in psychology, 14, 1195286. https://doi.org/10.3389/fpsyg.2023.1195286 • Gilomen, S. A., and Lee, C. W. (2015). The efficacy of acupoint stimulation in the treatment of psychological distress: a meta-analysis. J. Behav. Ther. Exp. Psychiatry 48, 140–148. doi: 10.1016/j.jbtep.2015.03.012 2 network analysis on cost effectiveness • Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Stockton, S., Meiser-Stedman, R., et al. (2019). Research review: psychological and psychosocial treatments for children and young people with post-traumatic stress disorder: a network meta-analysis. J. Child Psychol. Psychiatry 61, 18–29. doi: 10.1111/jcpp.13094 • Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., et al. (2020). Psychological treatments for post-traumatic stress disorder in adults: a network meta-analysis. Psychol. Med. 50, 542–555. doi: 10.1017/S0033291720000070 9 RCTs evaluating EFT for PTSD,	all of the systematic reviews highlighted by the commenter include studies that focused on PTSD symptoms, not PTSD diagnosis (and one was with adolescents). At this time, there are no systematic reviews of EFT meeting our PICOTS (i.e., adults with PTSD). Thus, EFT could not be considered. To avoid selection bias, the Panel did not consider individual clinical trials. However, we take this opportunity to acknowledge that there are many RCTs of energy psychology approaches for a range of mental health problems. However, it is misleading to imply that the Panel ignored over 200 clinical trials. The commenter highlights 9 RCTs, only one of which may fit our PICOTS: two enrolled adolescents, four enrolled individuals with PTSD symptoms (not PTSD diagnosis), and only one study (N=46) enrolled adults diagnosed with PTSD. Additional clinical trials of EFT, in adults with PTSD, and a systematic review of these trials would be needed for the Panel to consider this intervention. **References**

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I., et al. (2013). Psychological trauma symptom improvement in veterans using EFT (emotional freedom techniques): a randomized controlled trial. J. Nervous Mental Dis. 201, 153–116. doi: 10.1097/NMD.0b013e31827f6351 • Church, D., Piña, O., Reategui, C., and Brooks, A. (2012b). Single session reduction of the intensity of traumatic memories in abused adolescents after EFT: a randomized controlled pilot study. Traumatology18, 73–79. doi: 10.1177/1534765611426788 • Church, D., Sparks, T., and Clond, M. (2016). EFT (emotional freedom techniques) and resiliency in veterans at risk for PTSD: a randomized controlled trial. Explore J. Sci. Heal. 12, 355–365. doi: 10.1016/j.explore.2016.06.012 • Church, D., Yount, G., Rachlin, K., Fox, L., and Nelms, J. (2018c). Epigenetic effects of PTSD remediation in veterans using clinical EFT (emotional freedom techniques): a randomized controlled pilot study. Am. J. Health Promot. 32, 112–122. doi: 10.1177/0890117116661154 • Geronilla, L., Minewiser, L., Mollon, P., McWilliams, M., and Clond, M. (2016). EFT (emotional freedom techniques) remediates PTSD and psychological symptoms in veterans: a randomized controlled replication trial. Energy Psychol. Theory Res. Treat. 8, 29–41. doi: 10.9769/EPJ.2016.8.2.LG	Hoffman, V., Middleton, J. C., Feltner, C., Gaynes, B. N., Weber, R. P., Bann, C., Viswanathan, M., Lohr, K. N., Baker, C., & Green, J. (2018). *Psychological and pharmacological treatments for adults with posttraumatic stress disorder: a systematic review update* (AHRQ Publication No. 18-EHC011-EF). U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Link Institute of Medicine. (2011a). *Clinical practice guidelines we can trust.* National Academies Press. Link Institute of Medicine. (2011b). *Finding what works in health care: Standards for systematic reviews.* National Academies Press. Link Samson, D., & Schoelles, K. M. (2012). Chapter 2: Developing the topic and structuring systematic reviews of medical tests: Utility of PICOTS, analytic frameworks, decision trees, and other frameworks. In S. M. Chang, D. B. Matchar, G. W. Smetana, & C. A. Umscheid (Eds.) *Methods guide for medical test reviews* (AHRQ Publication No. 12-EHC017). U.S.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• Hartung, J., and Stein, P. (2012). Telephone delivery of EFT (emotional freedom techniques) remediates PTSD symptoms in veterans: a randomized controlled trial. Energy Psychol. Theory Res. Treat. 4, 33–39. doi: 10.9769/EPJ.2012.4.1.JH • Nemiro, A., and Papworth, S. (2015). Efficacy of two evidence-based therapies, emotional freedom technique (EFT) and cognitive behavioral therapy (CBT) for the treatment of gender violence in the Congo: a randomized controlled trial. Energy Psychol. Theory Res. Treat. 7, 13–25. doi: 10.9769/EPJ.2015.7.2.AN • Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., et al. (2011). A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: eye movement desensitization and reprocessing vs. emotional freedom techniques. J. Nervous Mental Dis. 199, 372–378. doi: 10.1097/NMD.0b013e31821cd262 • Al-Hadethe, A., Hunt, N., Ghaffar, A., and Thomas, S. (2015). Randomised controlled study comparing two psychological therapies for posttraumatic stress disorder: emotional freedom technique (EFT) vs. narrative exposure therapy (NET). J. Traumatic Stress Disord. Treat. 4, 1–12. doi: 10.4172/2324-8947.1000145	Department of Health and Human Services, Agency for Healthcare Research and Quality. Link

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Two of these RCT (an original and a replication study) found that EFT reduced PTSD in veterans by over 80% • Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I., et al. (2013). Psychological trauma symptom improvement in veterans using EFT (emotional freedom techniques): a randomized controlled trial. J. Nervous Mental Dis. 201, 153–116. doi: 10.1097/NMD.0b013e31827f6351 • Geronilla, L., Minewiser, L., Mollon, P., McWilliams, M., and Clond, M. (2016). EFT (emotional freedom techniques) remediates PTSD and psychological symptoms in veterans: a randomized controlled replication trial. Energy Psychol. Theory Res. Treat. 8, 29–41. doi: 10.9769/EPJ.2016.8.2.LG 3 RCTs comparing EFT to other modalities included in the clinical guidelines for PTSD. • Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., et al. (2011). A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: eye movement desensitization and reprocessing vs. emotional freedom techniques. J. Nervous Mental Dis. 199, 372–378. doi: 10.1097/NMD.0b013e31821cd262 • Al-Hadethe, A., Hunt, N., Ghaffar, A., and Thomas, S. (2015). Randomised controlled study comparing two psychological therapies for posttraumatic stress	

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		disorder: emotional freedom technique (EFT) vs. narrative exposure therapy (NET). J. Traumatic Stress Disord. Treat. 4, 1–12. doi: 10.4172/2324-8947.1000145 • Nemiro, A., and Papworth, S. (2015). Efficacy of two evidence-based therapies, emotional freedom technique (EFT) and cognitive behavioral therapy (CBT) for the treatment of gender violence in the Congo: a randomized controlled trial. Energy Psychol. Theory Res. Treat. 7, 13–25. doi: 10.9769/EPJ.2015.7.2.AN 2 papers on clinical guidelines for the use of EFT in PTSD. • Church, D., Stapleton, P., Mollon, P., Feinstein, D., Boath, E., Mackay, D., & Sims, R. (2018). Guidelines for the Treatment of PTSD Using Clinical EFT (Emotional Freedom Techniques). Healthcare (Basel, Switzerland), 6(4), 146. https://doi.org/10.3390/healthcare6040146 • Church, D., Stern, S., Boath, E., Stewart, A., Feinstein, D., and Clond, M. (2017). Using emotional freedom techniques (EFT) to treat PTSD in veterans: a review of the evidence, survey of practitioners, and proposed clinical guidelines. Permanente J. 21, 16–23. doi: 10.7812/TPP/16-100 The research has shown that EFT and other energy psychology approaches such as TFT are highly effective treatments that often work more rapidly with similar or	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		better outcomes compared to other gold standard treatments. EFT for PTSD has been evaluated by the Veterans Administration and has been accepted as safe and effective. Thousands of therapists use this approach and have treated tens of thousands of patients. Major medical institutions, including Kaiser Permanente and the Cleveland Clinic, utilize EFT and describe it on their websites. It does not serve the professional community or the public to purposefully or inadvertently exclude a viable treatment modality from consideration. For the Clinical Practice Guideline for the Treatment of PTSD in Adults to be an accurate assessment of the effective treatment options, EFT must be considered in the data review and then the data will speak for itself. To not do so raises a credibility question: "How can one of the most well-researched therapies in the world (more than 200 studies published in peer-reviewed journals show its effectiveness with a range of clinical conditions) not be included for evaluation in these guidelines?" We are aware that the approach has received impassioned criticism from a vocal minority of psychologists. But to support their position, they ignore the data on the effectiveness of EFT and instead frame it as either not actually being a psychological treatment or, even worse, alleging that it is a pseudoscience because of its use of tapping on meridian points (that are erroneously claimed to be non-existent). Some people claim that EMDR is effective only because of elements that are independent of its somatic component. Yet EMDR was included for review in the Clinical Practice	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Guideline for the Treatment of PTSD in Adults and found to be effective. Perhaps EFT was left out of the evaluation because it was not considered a psychological treatment. EFT is clearly a psychological intervention with a somatic component. EFT is a psychological intervention with a somatic component similar to EMDR. Both treatments utilize comparable psychological interventions but differ mainly in their somatic components: EMDR uses bilateral stimulation, and EFT uses tapping on acupuncture points.Research has shown that EFT and EMDR appear to be similarly effective (Karatzias et al. 2011). In the literature on EFT there has been considerable focus on the uniqueness of the "acupoint tapping". There have even been a number of dismantling studies showing that it is an active ingredient. But this leaves out the many psychological interventions that happen during treatment, especially with PTSD. These include procedures that: 1) help the client to create a more mindful perspective 2) as well as a more self-compassionate perspective 3) the practitioner helps to adjust the focus of awareness on specific memories and symptoms. EFT is an exposure treatment. However, the practitioner monitors and titrates the intensity of affect and emotional arousal in the patient and makes adjustments in the protocol to keep the patient within the optimal zone of arousal so that they do not become overwhelmed and retraumatized.	

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		4) In EFT, when a client recalls a traumatic memory, the practitioner structures the telling of the story into its component parts, focusing on specific elements of the memory one at a time. The client then taps on acupressure points while recounting each fragment of the memory, strategically targeting their physiological response to each part of the traumatic experience. By methodically tapping and reducing the SUDS (Subjective Units of Distress) to zero for each piece of the memory, this structured approach directly addresses the fight-or-flight response often triggered by trauma, calming the body through the regulation of the ANS. 5) This technique aligns with the core principles of Acceptance and Commitment Therapy (ACT), particularly the reduction of emotional avoidance, which is a key component of healing from trauma and psychological distress. ACT emphasizes the importance of confronting and accepting uncomfortable emotions rather than avoiding them. EFT invites the client to engage directly with the distressing memory while using tapping to downregulate the body's stress response. This gradual and controlled exposure, combined with physiological regulation, allows clients to process the trauma fully without becoming overwhelmed, which mirrors the goals of reducing emotional avoidance in ACT. 6) EFT's methodical approach to reducing distress through repeated, controlled exposure aligns with the fundamental principles of memory reconsolidation. By targeting traumatic	

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		memories in a manner that neutralizes their emotional charge, EFT ensures that these memories are permanently altered in the brain's storage system, much like other trauma-focused therapies that engage in memory reconsolidation. 7) EFT like EMDR is also grounded in Premack's TOTE model (Test-Operate-Test-Exit). This is a cognitive framework originally developed in the context of problem-solving and goal-directed behavior but can be applied to psychotherapy as a useful metaphor for understanding how therapeutic processes operate to bring about psychological change. Here's how the TOTE model breaks down and how it might apply to psychotherapy: 1. Test: This phase corresponds to assessing the client's distress related to specific traumatic memories. For each component of the story, the client assesses their distress level (SUDS score) before proceeding. 2. Operate: If the first "Test" shows that distress is still present, the "Operate" phase is initiated. In EFT: During this phase, the therapist would guide the client through tapping on acupressure points while focusing on specific traumatic elements. (in EMDR it would be bilateral stimulation)	

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		3. Test (again): After the intervention, a second "Test" occurs to determine whether the distress has been eliminated. 4. Exit: Once the distress is eliminated and the psychological issue has been resolved or reduced to a manageable level, the process concludes. In EFT: The Exit phase occurs when the client can recall the memory or discuss the issue without significant emotional distress (a SUDS score of zero or close to zero). EFT is an exposure-based psychological intervention Instead of relying on repetition of a large chunk of traumatic material (conventional exposure with very high arousal) EFT (1) combines imaginal exposure of smaller components with (2) a somatic component that sends deactivating signals to the limbic system during the exposure (3) that reduces the arousal in the presence of the previously traumatic image or event. This is repeated until the entire event is treated. EFT practitioners also assess what phase of trauma treatment a patient is in at any given moment. If a patient is in phase one and is in need of stabilization, then the approach is adjusted to help reduce arousal without necessarily treating specific memories. We have taken some time here to help correct the erroneous impression that EFT means just “tap on some points and problems magically vanish.” That is simply not the case. Critics often label EFT as pseudoscience due to its use of meridian points. However, plausible models of the	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		neurological mechanisms of tapping's effectiveness in overcoming psychological difficulties, with no reference to meridians, have been appearing in peer-reviewed journals for more than a decade. In regards to meridians, however, research indicates correlations between these points and connective tissue planes Langevin, H. M., & Yandow, J. A. (2002). Relationship of acupuncture points and meridians to connective tissue planes. Anatomical Record, 269(6), 257–265. doi:10.1002/ar.10185 and other research has found structures in the body that highly correlate with meridians called the primo vascular system. • Chikly, B., Roberts, P. & Quaghebeur, J. (2016). Primo Vascular System: A Unique Biological System Shifting a Medical Paradigm. Journal of Osteopathic Medicine, 116(1), 12-21. https://doi.org/10.7556/jaoa.2016.002 Lee B. H. (2024). A Perspective on the Identity of the Acupoint. Journal of acupuncture and meridian studies, 17(4), 111–115. https://doi.org/10.51507/j.jams.2024.17.4.111 • Lee, B. C., Akers, W. J., Jing, X., Perez, M. I., & Ryu, Y. (2013). Primo vascular system: past, present, and future. Evidence-based complementary and alternative medicine : eCAM, 2013, 240168. https://doi.org/10.1155/2013/240168 Stefanov, M., Potroz, M., Kim, J., Lim, J., Cha, R., & Nam, M. H.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		(2013). The primo vascular system as a new anatomical system. Journal of acupuncture and meridian studies, 6(6), 331–338. https://doi.org/10.1016/j.jams.2013.10.001 It is inappropriate to ignore this data as well as the data on the effectiveness of EFT and to engage in academic name calling of pseudoscience. The importance of including the body and autonomic regulation as part of treatment on PTSD is widely accepted in the world of trauma treatment. The exact mechanism or multiple mechanisms of working with the body as well as the mind still needs to be better understood, but plausible models of the neurological mechanisms of tapping's effectiveness in overcoming psychological difficulties have been appearing in peer-reviewed journals for more than a decade. In summary, the APA's Updated Clinical Practice Guideline for the Treatment of PTSD in Adults is derelict not to include the considerable efficacy research on EFT. Failure to do so deprives patients and clinicians of an effective innovation in the treatment for PTSD. We strongly suggest that EFT research must be included and assessed.	
Peta Stapleton (Individual)	General Comment	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology This current review does not include a treatment with more than 200 published trials: emotional freedom techniques (EFT). It appears the APA has determined EFT does not meet [the Board's] operational definition of a psychological treatment because the core assumptions about the	Thank you for your comment. EFT was not included because there was insufficient evidence to support a recommendation. Specifically, there are no systematic reviews of EFT that met our criteria (PTSD diagnosis, adults). The Panel did not consider the hypothesized mechanisms of EFT or make any

Commenter (Group or Individual?)	Section	Comment	Panel Response
		procedures and mechanisms of change in this treatment are neither founded in psychological science nor consistent with scientific understanding more broadly. This conclusion is seriously outdated. While early proponents of the method did turn to explanations derived from acupuncture theory to try to account for the rapid clinical outcomes they were observing, more up-to-date formulations presented in multiple peer-reviewed journals are fully compatible with contemporary psychological science and theory. This issue is thoroughly discussed, for instance, in a paper published in The Journal of Psychotherapy Integration (JPI). That paper was sternly critiqued by Cassandra Boness, Rory Pfund, and David Tolin in a commentary that is scheduled for publication, also in JPI, and answered point-by-point in a rejoinder. JPI presented the submitted rejoinder to reviewers who were highly skeptical about acupoint tapping as a legitimate psychotherapeutic intervention. The rejoinder's author then addressed, point-by-point, these critiques of the rejoinder. Upon evaluating the author's replies to the reviewer objections, JPI made the decision to accept the rejoinder for publication. A pre-print version of the rejoinder, as it will be published, can be accessed at https://osf.io/preprints/psyarxiv/ysg6u. Beyond JPI's determination, however, the facts speak for themselves. The original paper, the critique, and the rejoinder are simply the latest and most current version of a discussion that has been ensuing in the professional literature for more than two decades. The Boness et al. assertion that "The entire	determinations for inclusion/exclusion on this basis. Please see the response to the letter from the Association for Comprehensive Energy Psychology above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		rationale for EFT is based on the premise that tapping facilitates alterations in 'energy meridians,'" and thus the Board's primary concern about whether EFT meets the definition of a psychological treatment, is addressed in the rejoinder under the heading: "The Mechanisms of an Acupoint Tapping Approach" (pp. 3-9). The evidence presented in that section demonstrates that (a) Boness et al.'s conclusions, as well as the SCP Board's, are based on an outdated understanding of EFT and (b) an up-to-date assessment would recognize that EFT does meet the Board's operational definition of a psychological treatment on the mechanisms criterion. For instance, stimulating selected acupuncture points has been shown to generate electrical signals that downregulate excessive limbic system activity. Established measures also demonstrate that the procedure impacts gene expression in ways that correspond with positive clinical outcomes, and that it reduces cortisol production associated with the stress response. Meanwhile, dismantling studies demonstrate that the clinical effects of simulating acupuncture points are statistically superior to the effects of stimulating "sham" (non-acupuncture) points), establishing the stimulation of acupuncture points as an essential ingredient in the favourable clinical outcomes that have been documented in more than 170 clinical trials. As to the three other criteria for a psychological treatment: A psychological treatment is an intervention consisting of specific actions between a person or persons and a mental health professional or designee, with the intent of engaging cognitive, emotional, behavioural, or interpersonal processes,	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		in the service of modifying health or functional outcomes . . . We as a field doubt that there is any argument about EFT satisfying each of them. The other pivotal issue emphasized in Boness et al. involves their assertion that "the quality of the evidence for EFT, specifically in the treatment of PTSD, anxiety, and depression, is considered low." Again, this conclusion is based on outdated information. More than 95% of the 176 clinical trials currently published in legitimate peer-reviewed English-language journals found statistically significant improvement on at least one targeted outcome, often with unusual speed. In addition, head-to-head comparisons with CBT show EFT to have equivalent or superior outcomes. Support for these assertions can be found in the rejoinder to Boness et al. The rejoinder does acknowledge that meta-analyses of the more recent and more robust studies still need to be conducted, but the RCT evidence is very strong. As to meta-analyses, Boness et al. roundly criticized the one meta-analysis that had been conducted on PTSD clinical trials. After Boness et al. wrote their critique of the JPI paper, a study that virtually replicates the original PTSD meta-analysis was published in Frontiers in Psychology, the most widely-cited journal in the psychological sciences. The new study, using much more stringent criteria than the original meta-analysis, reached essentially the same clinically-favourable conclusions as the original about the efficacy of EFT in treating PTSD (disclosure: I am one of the authors of the new meta-analysis as it was included in our submission). Meanwhile, the same	

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		commentators as those on the JPI paper recently published a critique of this new meta-analysis. That critique, however, reflects the same assumptions, omissions, and biased interpretations as their commentary on the JPI paper. I am working with the authors of the new meta-analysis on a rejoinder to that commentary. Unfortunately, the misconceptions expressed by Boness et al. are shared by many in the clinical community whose opinions about energy psychology were formed decades ago when proponents of the method were making extraordinary claims before there was substantial evidence, or any empirical backing at all for that matter, not to mention no plausible explanation of mechanisms. The psychologists in the ad hoc group I represent (including a member of Division 12) are well aware of concerns that EFT not only looks strange but its efficacy claims and posited mechanisms remain controversial. It would be far easier in numerous ways for them to stick with modalities that are widely accepted. To speak to the pre-judgments that many have before witnessing or experiencing an EFT session – that it seems counter-intuitive for tapping on the skin to be an essential component of an effective psychotherapy – clinical innovations are often met with strong skepticism. Freud's "talk therapy" seemed counter-intuitive to the psychiatric community in the early days of psychoanalysis. The importance of washing hands before delivering babies seemed counter-intuitive to the medical community until the 1870s. David Burns noted in his most recent book that when CBT first appeared, "most psychiatrists	

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		and psychologists considered CBT a form of quackery" (2020, p. 452). Self-tapping on the body to bring about psychological benefits would, indeed, best be ignored except for the inconvenient fact that clinical trials and other forms of evidence are showing that it works. So far, despite request after request from the EFT community to Division 12, dating back over a decade, the Division has not found the evidence for the efficacy of EFT in treating PTSD and other serious clinical conditions to be adequate. However, other groups that are entrusted with making informed, high-stakes judgements on therapeutic modalities have been evaluating the same evidence and reaching different conclusions. For instance, a recent review of the influence of research on government policies found that EFT is mentioned in, or in the formation of, 398 government policies. I'll list just a few examples: • The US Veterans Administration convened an expert panel to examine evidence-based therapies for PTSD, and in 2017 classified EFT as an evidence-based therapy that is "generally safe" in the treatment of PTSD. • UNESCO recommends using acupoint tapping as a psychological intervention for children and parents during and following disasters. • The Department of Juvenile Justice of the Commonwealth of Virginia recommends EFT to manage stress, anxiety, and depression.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• The New York State Worker's Compensation Board found that EFT produced "significant clinical improvement in PTSD symptoms." • The American College of Occupational and Environmental Medicine's recommends EFT for working with depression. • Kaiser Permanente, the largest US healthcare provider, offers EFT sessions as well as self-help EFT instruction on its patient websites. • In the UK, the National Health Service does the same. The fact is that scores of institutions have convened expert panels and found EFT to meet the standards required of an approved primary care therapy. They are all focused on achieving effective evidence-based therapies to patients. Division 12 has a comparable mission: "support of the integration of clinical psychological science and practice in education, research, application, advocacy and public policy," but it has persisted as an anomaly and outlier in its determinations about EFT. Given all of this, we respectfully request that the APA include EFT in this review.	
Peta Stapleton (Individual)	Treatment Recommendations	The updated Clinical Practice Guideline for the Treatment of PTSD in Adults failed to include any of the research on EFT (Emotional Freedom Techniques) over the last 10 years. Meanwhile other approaches with far less research support were included for evaluation. EFT for PTSD has had at least 3 meta-analyses and systemic reviews	Thank you for your comment. APA develops its clinical practice guidelines in accordance with best practices for guideline development set forth by the National Academy of Medicine (formerly Institute of Medicine, 2011a & b). The Panel used the Population, Interventions, Comparators, Outcome, Timing, and Settings

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• Sebastian, B., and Nelms, J. (2017). The effectiveness of emotional freedom techniques in the treatment of posttraumatic stress disorder: a meta-analysis. Explore J. Sci. Heal. 13, 16–25. doi: 10.1016/j.explore.2016.10.001 • Stapleton, P., Kip, K., Church, D., Toussaint, L., Footman, J., Ballantyne, P., & O'Keefe, T. (2023). Emotional freedom techniques for treating post traumatic stress disorder: an updated systematic review and meta-analysis. Frontiers in psychology, 14, 1195286. https://doi.org/10.3389/fpsyg.2023.1195286 • Gilomen, S. A., and Lee, C. W. (2015). The efficacy of acupoint stimulation in the treatment of psychological distress: a meta-analysis. J. Behav. Ther. Exp. Psychiatry 48, 140–148. doi: 10.1016/j.jbtep.2015.03.012 2 network analysis on cost effectiveness • Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Stockton, S., Meiser-Stedman, R., et al. (2019). Research review: psychological and psychosocial treatments for children and young people with post-traumatic stress disorder: a network meta-analysis. J. Child Psychol. Psychiatry 61, 18–29. doi: 10.1111/jcpp.13094 • Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., et al. (2020). Psychological treatments for post-traumatic stress disorder in	(PICOTS) framework (a standard and systematic approach to conducting literature reviews across all fields of evidence-based medicine; Samson & Schoelles, 2012) to formulate the scope of its inquiry. Consistent with the Panel who developed the 2017 APA guidelines, the Guideline Update Panel set our population as adults with PTSD. While the systematic review conducted by the Agency for Healthcare Research and Quality (Hoffman et al., 2018) that served as the primary evidence base did include "energy psychology" in their literature searches, the authors were not able to find any studies that met their inclusion/exclusion criteria (i.e., PICOTS framework). At present, there are no systematic reviews of energy psychology approaches that meet our PICOTS. Specifically, all of the systematic reviews highlighted by the commenter include studies that focused on PTSD symptoms, not PTSD diagnosis (and one was with adolescents). At this time, there are no systematic reviews of EFT meeting our PICOTS (i.e., adults with PTSD). Thus, EFT could not be considered.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		adults: a network meta-analysis. Psychol. Med. 50, 542–555. doi: 10.1017/S0033291720000070 9 RCTs evaluating EFT for PTSD, • Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I., et al. (2013). Psychological trauma symptom improvement in veterans using EFT (emotional freedom techniques): a randomized controlled trial. J. Nervous Mental Dis. 201, 153–116. doi: 10.1097/NMD.0b013e31827f6351 • Church, D., Piña, O., Reategui, C., and Brooks, A. (2012b). Single session reduction of the intensity of traumatic memories in abused adolescents after EFT: a randomized controlled pilot study. Traumatology18, 73–79. doi: 10.1177/1534765611426788 • Church, D., Sparks, T., and Clond, M. (2016). EFT (emotional freedom techniques) and resiliency in veterans at risk for PTSD: a randomized controlled trial. Explore J. Sci. Heal. 12, 355–365. doi: 10.1016/j.explore.2016.06.012 • Church, D., Yount, G., Rachlin, K., Fox, L., and Nelms, J. (2018c). Epigenetic effects of PTSD remediation in veterans using clinical EFT (emotional freedom techniques): a randomized controlled pilot study. Am. J. Health Promot. 32, 112–122. doi: 10.1177/0890117116661154 • Geronilla, L., Minewiser, L., Mollon, P., McWilliams, M., and Clond, M. (2016). EFT (emotional freedom techniques) remediates PTSD and psychological	To avoid selection bias, the Panel did not consider individual clinical trials. However, we take this opportunity to acknowledge that there are many RCTs of energy psychology approaches for a range of mental health problems. However, it is misleading to imply that the Panel ignored over 200 clinical trials. The commenter highlights 9 RCTs, only one of which may fit our PICOTS: two enrolled adolescents, four enrolled individuals with PTSD symptoms (not PTSD diagnosis), and only one study (N=46) enrolled adults diagnosed with PTSD. Additional clinical trials of EFT, in adults with PTSD, and a systematic review of these trials would be needed for the Panel to consider this intervention. **References** Hoffman, V., Middleton, J. C., Feltner, C., Gaynes, B. N., Weber, R. P., Bann, C., Viswanathan, M., Lohr, K. N., Baker, C., & Green, J. (2018). *Psychological and pharmacological treatments for adults with posttraumatic stress disorder: a systematic review update* (AHRQ Publication No. 18-EHC011-EF). U.S. Department of Health and

Commenter (Group or Individual?)	Section	Comment	Panel Response
		symptoms in veterans: a randomized controlled replication trial. Energy Psychol. Theory Res. Treat. 8, 29–41. doi: 10.9769/EPJ.2016.8.2.LG • Hartung, J., and Stein, P. (2012). Telephone delivery of EFT (emotional freedom techniques) remediates PTSD symptoms in veterans: a randomized controlled trial. Energy Psychol. Theory Res. Treat. 4, 33–39. doi: 10.9769/EPJ.2012.4.1.JH • Nemiro, A., and Papworth, S. (2015). Efficacy of two evidence-based therapies, emotional freedom technique (EFT) and cognitive behavioral therapy (CBT) for the treatment of gender violence in the Congo: a randomized controlled trial. Energy Psychol. Theory Res. Treat. 7, 13–25. doi: 10.9769/EPJ.2015.7.2.AN • Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., et al. (2011). A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: eye movement desensitization and reprocessing vs. emotional freedom techniques. J. Nervous Mental Dis. 199, 372–378. doi: 10.1097/NMD.0b013e31821cd262 • Al-Hadethe, A., Hunt, N., Ghaffar, A., and Thomas, S. (2015). Randomised controlled study comparing two psychological therapies for posttraumatic stress disorder: emotional freedom technique (EFT) vs. narrative exposure therapy (NET). J. Traumatic Stress	Human Services, Agency for Healthcare Research and Quality. Link Institute of Medicine. (2011a). *Clinical practice guidelines we can trust.* National Academies Press. Link Institute of Medicine. (2011b). *Finding what works in health care: Standards for systematic reviews.* National Academies Press. Link Samson, D., & Schoelles, K. M. (2012). Chapter 2: Developing the topic and structuring systematic reviews of medical tests: Utility of PICOTS, analytic frameworks, decision trees, and other frameworks. In S. M. Chang, D. B. Matchar, G. W. Smetana, & C. A. Umscheid (Eds.) *Methods guide for medical test reviews* (AHRQ Publication No. 12-EHC017). U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Link

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Disord. Treat. 4, 1–12. doi: 10.4172/2324-8947.1000145 Two of these RCT (an original and a replication study) found that EFT reduced PTSD in veterans by over 80% • Church, D., Hawk, C., Brooks, A., Toukolehto, O., Wren, M., Dinter, I., et al. (2013). Psychological trauma symptom improvement in veterans using EFT (emotional freedom techniques): a randomized controlled trial. J. Nervous Mental Dis. 201, 153–116. doi: 10.1097/NMD.0b013e31827f6351 • Geronilla, L., Minewiser, L., Mollon, P., McWilliams, M., and Clond, M. (2016). EFT (emotional freedom techniques) remediates PTSD and psychological symptoms in veterans: a randomized controlled replication trial. Energy Psychol. Theory Res. Treat. 8, 29–41. doi: 10.9769/EPJ.2016.8.2.LG 3 RCTs comparing EFT to other modalities included in the clinical guidelines for PTSD. • Karatzias, T., Power, K., Brown, K., McGoldrick, T., Begum, M., Young, J., et al. (2011). A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: eye movement desensitization and reprocessing vs. emotional freedom techniques. J. Nervous Mental Dis. 199, 372–378. doi: 10.1097/NMD.0b013e31821cd262	

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		• Al-Hadethe, A., Hunt, N., Ghaffar, A., and Thomas, S. (2015). Randomised controlled study comparing two psychological therapies for posttraumatic stress disorder: emotional freedom technique (EFT) vs. narrative exposure therapy (NET). J. Traumatic Stress Disord. Treat. 4, 1–12. doi: 10.4172/2324-8947.1000145 • Nemiro, A., and Papworth, S. (2015). Efficacy of two evidence-based therapies, emotional freedom technique (EFT) and cognitive behavioral therapy (CBT) for the treatment of gender violence in the Congo: a randomized controlled trial. Energy Psychol. Theory Res. Treat. 7, 13–25. doi: 10.9769/EPJ.2015.7.2.AN 2 papers on clinical guidelines for the use of EFT in PTSD. • Church, D., Stapleton, P., Mollon, P., Feinstein, D., Boath, E., Mackay, D., & Sims, R. (2018). Guidelines for the Treatment of PTSD Using Clinical EFT (Emotional Freedom Techniques). Healthcare (Basel, Switzerland), 6(4), 146. https://doi.org/10.3390/healthcare6040146 • Church, D., Stern, S., Boath, E., Stewart, A., Feinstein, D., and Clond, M. (2017). Using emotional freedom techniques (EFT) to treat PTSD in veterans: a review of the evidence, survey of practitioners, and proposed clinical guidelines. Permanente J. 21, 16–23. doi: 10.7812/TPP/16-100	

Commenter (Group or Individual?)	Section	Comment	Panel Response
Katherine Pratt (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the panel's responses to Prof. Stapleton's comment above.
Lisa Evans (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the panel's responses to Dr. Schwartz and Prof. Stapleton's comments above.
Nirelle Bennett (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, and support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kate Helder (Individual)	Treatment Recommendations	I fully support Professor Peta Stapleton's comment in addition to the comment from Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. Witnessing first hand the profound impact that Emotional Freedom Techniques has on individuals in traumatised communities, it would be abhorrent to overlook the valid research as detailed by Professor Peta Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sheryl Sazenis (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment" too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Genevieve Smith (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz and support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Karen KL Chang (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. EFT is the most effective and the most cost-effective therapy for PTSD in adult	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kimberly Jackson-Massaro (Individual)	Treatment Recommendations	EFT has convincing evidence to support this protocol as a safe, gentle, and effective treatment for adult with PTSD. I agree with Dr. Robert Schwartz and Dr. Peta Stapleton	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sarah GL (Individual)	Treatment Recommendations	I fully support Professor Peta Stapleton's comment in addition to the comment from Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Caroline Croteau (Individual)	Treatment Recommendations	I fully support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Suzanne Demers (Individual)	Treatment Recommendations	I think it is a terrible oversight to dismiss the use of Clinical EFT in processing PTSD. I speak as someone who has suffered with Complex -PTSD for most of my life. Starting at 13 I have been trying to process through psychological, sexual, emotional, and spiritual abuse. Of course pepper in the chronic depression, suicidal ideations, injustice of the judicial system, incidents of cancer (mine and family members), the almost fatal car accidents of my niece (that left her 2 months in a coma in which she nearly died twice, 8 months of recover leaving her with a massive brain injury, blindness and a limp, the suicide of a 10yr old student, crippling flashbacks, so you	Thank you for your comment and for sharing your personal experience of benefiting from this approach. The omission of EFT in the guidelines does not indicate that the Panel has deemed EFT to be ineffective. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of

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		might have a tiny taste of what I have had to and continue to process. I have literally spent decades in therapists, counselors, psychiatrists offices, with only the tendiously slow progress to reducing my PTSD. I have tried mindfulness, somatics, and so many other. I have taken and rejected the medications. I did EMDR for over 2years and dispite that this did show significant progress until my therapist could no longer handle the flashbacks it was causing. At which time in my desperation, I found EFT, the simplist and most brilliant concept. I have been able to clear vast amounts of my trauma using this technique and at a pace unequalled to any other modality many of which you have listed in your report. I believe so strongly in Clinical EFT that I have been working on my certification to become a practicioner. I use this technique in my classroom to reduce student anxiety it is that simplistic. I have worked with clients to clear highly traumatic events within a few sessions (watching someone die at the scene of an accident, sexual harrasment on the job, processing and releasing the trauma of family beliefs around sexuality, body crippling pain, physical trauma of accidents and injuries.) Speaking with almost 50yrs of experience, it is a gross oversight to dismiss Clinical EFT. It has the scientific backing to demonstrate its effectiveness. But as a client and practisioner this is by far the most effective PTSD reducing/clearing modality I have found. The Tearless Trauma techniques allow me to process through my childhood abuse, without ever having to let my practisioner know of the brutality of my violations. This is all done within a few sessions, despite the years and years that I spent in more	EFT meeting these criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		traditional talk therapy settings. This is a detrimental oversight for those of use suffering with PTSD.	
Shawn Russell (Individual)	Treatment Recommendations	Great progress has come from paying attention to qualitative data. Not everything can be explained in a box and qualitative data allows for the complexity of human experience. Methods such as EFT have enormous amounts of qualitative data that points to something greatly beneficial happening. So either everyone is making it up, in which case the placebo effect of the method should be explored, or it's actually producing the results people say it is. Either way, EFT, and other methods that have been overlooked by a small group of people but embraced by many more, have a lot to offer the world of mental wellbeing. I vote to include them. Thank you.	Thank you for your comment. Anecdotal evidence was not considered when making recommendations because this form of evidence is much more prone to bias than other forms of evidence. The omission of EFT in the guidelines does not indicate that the Panel has deemed EFT to be ineffective or that anecdotal reports are false. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. There are no systematic reviews of EFT meeting these criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence.
Bert Hill (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's and Dr Robert Schwartz' comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Karlo Seci (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's and Dr Robert Schwartz' comments	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Dianne Nash (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kirsty Mitchell (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sue Klassen (Group: ACEP)	Treatment Recommendations	I support ACEP's comment and the input of Dr. Peta Stapleton. I am concerned that the strong research base for effective use of Clinical EFT for PTSD has not been reflected in APA's guidelines to date.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Pennie Treado (Individual)	Treatment Recommendations	I support ACEP's comment." or I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology".	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jerre Weaver (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lorrie Herzberg (Individual)	Treatment Recommendations	It is amazing to me that you disregard substantive research confirmation about the validity of EFT in the treatment of PTSD. I can only surmise that there here is either an economic motivation or political motivation, that is to keep treatment power in the hands of those who do not favor EFT. I assume	Thank you for your comment. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel

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		it's some point that there was some idealism behind your choice to enter your profession. Perhaps you can reconnect with what once motivated you. As a Hospice Social Worker, I introduced many, many people to EFT and received thanks for the profound impact it had during a time of profound suffering. Candidly, I do not understand the thinking of an organization that would withhold approval of a legitimate, effective modality. But then perhaps you would have voted against penicillin if you've been in the position to do so.	considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence.
Florence Levia (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz on behalf of group ACEP (The Association for Comprehensive Energy Psychology), and support Professor Peta Stapleton's comment as well. EFT has been well studied, is low-cost and efficacious in improving outcomes for PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sue Mirkin (Individual)	Treatment Recommendations	Healing from trauma occurs over time and is very individual. Approaching PTSD requires sensitive and creative, arts-based interventions that include ALL human faculties. This allows the fullness of the human spirit and soul to be reclaimed and be present in this world. I support PsiAN's position	Thank you for your comment. The guidelines are aspirational and intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. The guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive, and they are not intended to take precedence over the judgment of psychologists. Please refer to the response to the PsiAN letter above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Heather Lakatos (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz on behalf of group ACEP (The Association for Comprehensive Energy Psychology), and support Professor Peta Stapleton's comment as well. EFT has been well studied and is low-cost.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lucinda Mora (Group: ACEP)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kathleen Weber (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I would also like to share my personal story with PTSD. I had the nightmares, the flashbacks, the brain fog, and heaviness in my body that accompanies PTSD. I worked with a therapist who used CBT and although it helped after working with her for several months, my symptoms were completely re-triggered a few years later. It felt as if I hadn't done any therapy at all. That's when I was first introduced to EFT. I worked with a Certified Practitioner and within 3 sessions, I felt more relief than I had with all of my counseling sessions combined. I felt SAFE in my body, which did not happen with CBT. I had never experienced that kind of relief. I am a former School Counselor and am now an Advanced, Certified and Accredited EFT Practitioner. The post-traumatic growth I see with my clients is truly remarkable. EFT changed my life and it is changing the lives of so many people around the world who work with Certified Practitioners.	Thank you for your comment and for sharing your personal experience of benefiting from this approach. The omission of EFT in the guidelines does not indicate that the Panel has deemed EFT to be ineffective. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Melissa Lanin (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology".	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Monica Marinescu (Individual)	Treatment Recommendations	I appreciate the APA's commitment to updating the Clinical Practice Guidelines for the Treatment of PTSD in Adults. Ensuring evidence-based recommendations is crucial for improving patient outcomes. However, I urge the APA to consider including research on alternative and complementary therapies such as Energy Psychology, EFT (Emotional Freedom Techniques), and TFT (Thought Field Therapy). These approaches have demonstrated significant benefits in clinical studies, particularly for trauma recovery. Including these modalities in the guidelines would provide clinicians with more comprehensive tools for personalized patient care, thereby enhancing the effectiveness of PTSD treatments. Expanding the range of therapies acknowledged by the APA would align with the organization's mission to support diverse, evidence-based mental health solutions. Thank you for considering this feedback as part of your ongoing efforts to enhance PTSD. Sincerely, Monica Marinescu	Thank you for your comment. Complementary and integrative health interventions were identified as an area of interest by the Panel and available evidence of these interventions was considered. At this time, there are no systematic reviews of energy psychology approaches meeting our PICOTS criteria. Thus, EFT and TFT could not be considered. There may be many therapeutic approaches, including EFT and TFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence.
Vanita Kaneson (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. Please take the time to look at the research.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Christine Gibson (Individual)	Treatment Recommendations	I strongly support Peta Stapleton's suggestion. As a GP traumatologist, I find that there are somatic skills that are	Thank you for your comment. Prior to reviewing the evidence, the Panel set the

Commenter (Group or Individual?)	Section	Comment	Panel Response
		highly efficacious in the management of trauma that are not included in past guidelines. EFT and Matrix Reimprinting are two of the most effective tools that I use in my practice - PTSD in refugees and complex trauma in adult addiction therapy. I hope that the recent evidence is included and considered. Somatic and psychosensory modalities have a place in our compendium of therapeutic interventions.	scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these PICOTS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Marianne Vreugdenhil (Individual)	Treatment Recommendations	I am a counsellor and EFT practitioner with a degree in social work. I agree with Dr Peta Stapleton regarding the efficacy of somatic therapies such as EFT (Emotional Freedom Techniques) in treating PTSD. In my work, I have personally observed clients receive sustained relief from symptoms of trauma after using EFT. I urge the APA to include this set of techniques as one of the possible avenues of treatment for clients with PTSD.	Thank you for your comment. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these PICOTS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please see the responses to the letter from the

Commenter (Group or Individual?)	Section	Comment	Panel Response
			Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nina Nyback (Individual)	Treatment Recommendations	I support ACEP's comment with the comment by Dr. Robert Schwartz. I also support Professor Peta Stapleton's comment. Lot's of meta-analysis and detailed clinical studies have been done around the use of PTSD, and looks like an effective alternative. Please review EFT as a practice for use in treatment of PTSD in Adults.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Angela Ryan (Individual)	Treatment Recommendations	I support Peta Stapleton's comments. The research on the efficacy of EFT is impressive and so are the benefits of EFT for people who have experienced trauma.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Rita Crockett (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment. I have experience working with clients who have PTSD for 25 years.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Katia Loizou (Individual)	Treatment Recommendations	I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kathy Moore (Group: ACEP)	Treatment Recommendations	I support The Association for Comprehensive Energy Psychology's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Karen McClemens (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I support ACEP's comment, and I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Energy Psychology. I totally agree that the use of EFT has the evidence and is effective as a treatment modality for PTSD, Client feedback also supports the effectiveness of assisting in the treatment of PTSD	for Comprehensive Energy Psychology and Professor Stapleton above.
Clare Jehu (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment regarding Evidence based EFT for the treatment of PTSD. I feel it is important to look at all treatment for PTSD to gain a greater understanding and knowledge of treatments with successful outcomes.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kesta Fleming (Individual)	Treatment Recommendations	I support both Robert Schwartz and Dr Peta Stapleton's comments arguing for the inclusion of EFT for evaluation in the updated clinical Practice Guidelines for the Treatment of PTSD in Adults. Both Schwartz and Stapleton cite the extensive and high quality research that has been carried out over the last decade demonstrating the efficacy of EFT in treating trauma and PTSD in their comments. This research is widely known and accepted by numerous other organisations. It would be remiss of the APA to exclude EFT and not give this intervention a fair opportunity to be evaluated head to head with other approaches that have far less research than EFT for the treatment of PTSD. There is great need for effective treatments of stress, trauma and PTSD in our communities. To exclude a treatment widely known to be effective from the Practice Guidelines would be to do a disservice to those in genuine need of treatment. I urge the board to reconsider the inclusion of EFT for evaluation.	Thank you for your comment. Please see our responses to the referenced comments. In brief, prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these PICTOS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence.
Yael Shimoni (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		support Professor Peta Stapleton's comment regarding Clinical EFT.	for Comprehensive Energy Psychology and Professor Stapleton above.
Veriza Smith (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. Once again, the APA has completely ignored energy psychology and EFT. You did not include any of the published EFT research or meta analyses on trauma or PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
MS 121 (Individual)	Treatment Recommendations	I support ACEP's comment." I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I support Professor Peta Stapleton's comment" too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lesley Taylor (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment regarding Evidence based EFT for the treatment of PTSD. I feel it is important to look at all treatment for PTSD to gain a greater understanding and knowledge of treatments with successful outcomes.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Prakash Biswas (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I am an EFT practitioner and have been using this technique successfully in many cases of PTSD and Panic Attacks and the results are most encouraging within unusual short time.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ana Jeremiah (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment and I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kelly Shadbolt (Individual)	Treatment Recommendations	Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and also the comments of Professor Peta Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Serena Mira Asta (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment as well. I am a certified clinical EFT practitioner, and have successfully used EFT with many clients suffering from PTSD. I have also been a client using EFT to treat my own PTSD with great success. Thank you for your consideration. I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment as well.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jodi Tala (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment and I support and agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joanne Gibbs (Individual)	Treatment Recommendations	As a registered heath care professional, nurse, counsellor and trainer, I support Professor Peta Stapleton's comments. EFT is a feasible, economical and evidence based tool that benefits clients, health care professionals and patients. I use it in hospitals for medical, allied health and nursing staff as well as for oncology patients suffering from PTSD. In my personal and professional opinion it would be remiss of the APA to exclude this in the treatment criteria.	Thank you for your comment. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for

Commenter (Group or Individual?)	Section	Comment	Panel Response
			addressing PTSD, but do not, at present, have sufficient scientific evidence.
Tammy Ockerse (Group: ACEP)	Treatment Recommendations	I support ACEP's comment. I support Dr PETA Stapleton comment and my own experience as a mental health OT who has helped many people including myself to reduce PTSD using EFT	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nicola Murrau (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kicki Lekberg (Individual)	Treatment Recommendations	EFT is an effective, safe, gentle and cost-effective therapy for PTSD in adult. EFT has convincing evidence in more than 200 published trials. I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Markéta Za (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gaylene Hansen (Individual)	Treatment Recommendations	As a registered nurse, Emotional Freedom Technique and Energy Psychology Practitioner who has worked with many individual people with PTSD, I support Professor Peta Stapleton's comment. comment"	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Petra Brunnbauer (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Emmalee Pepar (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment on this topic. In an age where we have many leading psychological experts sharing research and clinical experience of trauma being stored in the body, somatic/body based techniques such as EFT are not only fast and effective, but could significantly enhance the effectiveness of other clinical practices	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joanne Morrell (Individual)	Treatment Recommendations	I support ACEP's statements	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Shannon Douglas (Individual)	Treatment Recommendations	I had a very traumatic experience on 19 November 1989 and struggled with it for many many years, until I found EFT. This incredibly gentle, safe and powerfully effective intervention has helped me incredibly both psychologically and emotionally to overcome my trauma. So as someone who has suffered from PTSD for decades and because of the efficacy EFT and the extremely positive effect it has had on my transformation, I am now an Accredited Advanced EFT Practitioner. I therefore know full well and first hand the efficacy of this modality for treating PTSD. Therefore, on behalf of all PTSD sufferers everywhere, I request that EFT be accepted and included as a treatment in your Clinical Practice Guideline for the Treatment of PTSD. General Comments:I had a very traumatic experience on 19 November 1989 and struggled with it for many many years, until I found EFT. This incredibly gentle, safe and powerfully effective intervention has helped me incredibly both psychologically and emotionally to overcome my trauma. So	Thank you for your comment and for sharing your personal experience of benefiting from this approach. The omission of EFT in the guidelines does not indicate that the Panel has deemed EFT to be ineffective. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these PICOTS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please also see the responses to the letter

Commenter (Group or Individual?)	Section	Comment	Panel Response
		as someone who has suffered from PTSD for decades and because of the efficacy EFT and the extremely positive effect it has had on my transformation, I am now an Accredited Advanced EFT Practitioner. I therefore know full well and first hand the efficacy of this modality for treating PTSD. Therefore, on behalf of all PTSD sufferers everywhere, I request that EFT be accepted and included as a treatment in your Clinical Practice Guideline for the Treatment of PTSD.	from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Enrique Parada (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment on this topic. In an age where we have many leading psychological experts sharing research and clinical experience of trauma being stored in the body, somatic/body based techniques such as EFT are not only fast and effective, but could significantly enhance the effectiveness of other clinical practices.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Fiona Vigar (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and as an experience practitioner have had significant success with EFT. I am not sure why you would not consider the meta analyses and body of published data.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Silke Johnson (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Charlotte Thomson (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Emily Andrew (Individual)	Treatment Recommendations	I think that neglecting recent research in the field of EFT due to wilful ignorance and biased personal opinion is extremely problematic and agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment and would urge the APA to be more open minded and more neutral when looking into this field in order to benefit the public and improve mental health the world over.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Vida Radzeviciene (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Verena Hamburg (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Benjamin Hargrave	Treatment Recommendations	I agree with Dr Robert Schwarz who has provided comment on behalf of: ACEP - The Association for Comprehensive Energy Psychology. As a qualified social worker who has worked with developmentally traumatised children and adults for over 20 years, I have found EFT extremely effective in managing the experience and symptoms of PTSD, particularly including its use to support people who have experienced specific incidences of sexual assault and rape. I am a qualified social worker, a systemic practitioner, a DDP Practitioner, Consultant and Trainer; and an EFT Practitioner. I am currently co-chair of the DDPI Worldwide Board of Directors.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

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Chrissie Neary (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jas Dale (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lef De Keersmaecker (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Deirdre Amies (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Karen Pringle (Individual)	Treatment Recommendations	"I support Professor Peta Stapleton's comment" too or any other comments that have been posted on the topic.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Katarzyna Ofman (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Iwona Kotowska (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Georgina Berriman (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alberto Verzellesi (Individual)	Treatment Recommendations	I support ACEP's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mairead Gilheany (Individual)	Treatment Recommendations	I am an EFT Practitioner who has treated many clients with PTSD and have seen great results with this modality. It restores a person, removed the trauma as it is a somatic therapy, and rewires the brain to enjoy life instead of surviving. It is cost effective and takes a shorter time than other therapies. The client is astonished at the change they feel through EFT. I support the comments of Professor Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Marta Vojnic Purcar (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I personally have tremendously benefited from EFT in healing my trauma, when nothing else worked. It is certainly worth considering all the scientific research and meta analyses that follow APA guidelines. Mainstream evidence-based psychological treatments should include as many modalities validated by research as possible, so there is more choice for patients in hospitals and other settings across the world. EFT is gentle, unbelievably powerful, delivers fast results and has lasting effects, speaking from personal experience. Talking therapies	Thank you for your comment and sharing your personal experience. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		would benefit from combining with a somatic modality like EFT in delivering even better outcomes. I hope APA will consider the submitted research conducted by Dr Peta Stapleton and other scientists in support of EFT to be included in the list of evidence-based therapies. Thank you.	
T Wallace (Individual)	Treatment Recommendations	I support Professor Peta Stapletons comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Naomi Bourke (Individual)	Treatment Recommendations	I support Dr Peta Stapleton's comments. There is clear evidence that EFT is an effective treatment for PTSD in adults. Just because the mechanism of how EFT works for treating PTSD is not fully understood yet is not a valid reason for dismissing it as a treatment option. Please consider the growing body of evidence that EFT is a cost effective treatment for PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nikkie Foster (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joanna Lum Wai (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Peter Rosvelds (Individual)	Treatment Recommendations	Please, do not forget your own findings!!!!!!! Combining Acupressure with Established Psychological Methods Improves Clinical Outcomes - Journal of Psychotherapy Integration, May 2022, American Psychological Association	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		(APA) The integration of techniques from acupressure into conventional psychotherapy has been the subject of more than 300 peer-reviewed journal articles, including over 125 clinical trials. This review finds that this evidence shows the approach to be not only effective, but unusually rapid and that the improvements are durable. The mechanisms that lead to these outcomes, implications for clinicians, and directions for future research are all discussed. And also : I support Professor Peta Stapleton's comment"	for Comprehensive Energy Psychology and Professor Stapleton above.
Volodymyr Tanashchuk (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Andrea Quintal Portas (Individual)	Treatment Recommendations	I fully agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and Dr. Peta Stapleton comments. As a Quantum Health Coach and Clinical EFT Practitioner, I see how EFT helps individuals to release and process trauma while supporting their mentally healthy self-awareness. It is about time to modernize psychology and accept the integrations of science, quantum and spirituality while supporting individuals to attain psychological support that is simple, safe, affordable and effective.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Claire Linley Schillaci (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Kasia Halani (Individual)	Treatment Recommendations	I support ACEP's COMMENT I agree with Dr Robert Schwarz on behalf of Group: ACEP I support Prof Peta Stapleton comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Susan Lynch (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Maxine Croft (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jasmin Braun (Individual)	Treatment Recommendations	I fully support the comments of Professor Peta Stapleton and Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology on the effectiveness of Energy Psychology and EFT in treatment of PTSD in Adults. I fully support the comments of Professor Peta Stapleton and Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kristin Panasewicz (Individual)	Treatment Recommendations	As a PTSD survivor, trauma healer, and EFT Practitioner, I am appalled that Energy Psychology has not been included in this. This shortsightedness has the potential to deprive thousands of individuals suffering from PTSD a gentle, highly effective, and relatively quick treatment for their symptoms. Energy Psychology, namely Emotional Freedom Techniques, quite literally kept me alive when other modalities failed me during the peak of my PTSD symptoms. The relief this technique provided was immediate, nourishing, and permanent. I fully	Thank you for your comment and for sharing your personal experience of benefiting from this approach. The omission of EFT in the guidelines does not indicate that the Panel has deemed EFT to be ineffective. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices

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		support Dr. Peta Stapleton's comments and those of Dr. Robert Schwarz on behalf of ACEP.	for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these PICOTS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please also see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lizzie Simpson (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anette Eriksson (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" I also support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jennifer Wood (Individual)	Treatment Recommendations	I support the comments of Prof. Pete Stapleton. I agree with the comments of Dr Robert Schwartz and Professor Peta Stapleton, and I support the Association of Comprehensive Energy Psychology's submission.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Emma Alessii (Individual)	Treatment Recommendations	I agree with the comments of Dr Robert Schwartz and Professor Peta Stapleton, and I support the Association of Comprehensive Energy Psychology's submission.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Mikaela Qviberg (Individual)	Treatment Recommendations	I support Dr Peta Stapleton's comments. There is clear and convincing evidence that EFT is an effective and cost effective form of treatment for PTSD in adults. Please consider including this technique in your guidelines.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Emma Roberts (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sandra McLagan (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alexandra Walker (Individual)	Treatment Recommendations	I support Dr Peta Stapleton's comments. There is clear and convincing evidence that EFT is an effective and cost effective form of treatment for PTSD in adults. Please consider including this technique in your guidelines.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kanika Gupta (Individual)	Treatment Recommendations	I am a counselling psychologist who have been exploring and using Clinical EFT since 2003. I have personally experienced it's benefits and have used EFT(with informed consent) on my clients and they have benefitted it espc in case of trauma and PTSD. Now there are number of scientific papers affirming it's efficacy . In my experience EFT is even more user friendly and faster than FDA approved EMDR . I would request you to reconsider your decision and have a open mind approach towards EFT. I agree with "Dr Robert Schwartz	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		on behalf of Group: ACEP- The Association for Comprehensive Energy Psychology and Dr Peta Stapleton comments.	
Kayla Nolen (Individual)	Treatment Recommendations	I agree with Dr. Peta Stapelton's comments. There is clear and convincing evidence that EFT is an effective and cost effective form of treatment for PTSD in adults. Please consider including this technique in your guidelines	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Marissa Fazio Haering (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ooha Maruri (Individual)	Treatment Recommendations	As a trauma survivor, EFT client and a certified EFT Practitioner, I have experienced the benefits of EFT in helping me recover and heal from multiple issues related to trauma. Therefore, I agree with Dr Peta Stapleton and Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I agree with Dr Peta Stapleton and Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kirsten Buchholtz (Individual)	Treatment Recommendations	I support Dr Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anitha Vasudevan (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

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Alice Bradshaw (Individual)	Treatment Recommendations	I agree with Professor Peta Stapleton's comment and Dr Robert Schwartz's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Emma Ashton (Individual)	Treatment Recommendations	As a trauma survivor and EFT practitioner with experience in working with trauma and PTSD I strongly agree with Dr Robert Schwarz's comments on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anna Lefkati (Individual)	Treatment Recommendations	As a trauma survivor that healed from PTSD with EFT, I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lotta Astré (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" I also support Professor Peta Stapleton's comment. There is clear and convincing evidence that EFT is an effective and cost effective form of treatment for PTSD in adults. Please consider including this technique in your guidelines.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Marina Engelstad (Individual)	Treatment Recommendations	I support ACEP's comment. I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Glenn Kinderman (Individual)	Treatment Recommendations	I support ACEP's and Peta Stapleton's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Jessica Dery (Group: ACEP)	Treatment Recommendations	[PASTED COMMENTS FROM ACEP]. This practice has been essential in healing my own trauma and an asset in addressing the trauma within my patients. I am able to discharge patients without medication or residual symptoms as a result of this treatment. For those suffering from PTSD, it is imperative to include all effective treatment options. If the medical community or general population is unaware of Energy Psychology as a treatment option, how are they able to make the best decision for their care.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jayesh Suri (Individual)	Treatment Recommendations	EFT is effective for PTSD treatment also check operation emotional freedom for war veterans by Gary Craig Dr Robert and Peta have done amazing job to document clinical aspect and I support their say that EFT is incredible and life changing...re consider if you have not.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Annelie Forsell (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elisa Donghi (Individual)	Treatment Recommendations	As a Clinical Psychologist, and Psychotherapist I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Stefania Comerci (Individual)	Treatment Recommendations	As a Clinical Psychologist, and Psychotherapist I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Susan Temple (Individual)	Treatment Recommendations	I support the comments of ACEP and Dr. Peta Stapleton. I am an Emotional Freedom Techniques practitioner, and I see	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		every day how tapping changes lives. Please review the current research and consider adding EFT as an approved treatment for PTSD in adults.	for Comprehensive Energy Psychology and Professor Stapleton above.
David Brillhart, PsyD (Individual)	Treatment Recommendations	As a licensed psychologist specializing in the treatment of CPTSD for narcissistic abuse recovery and chronic pain, I, without reservation, support the Association for Comprehensive Energy Psychology's (ACEP) recommendation of Emotional Freedom Technique (EFT) within the APA's clinical practice PTSD guidelines. I am trained/certified in EMDR and Brainspotting, and advanced trained in EFT. Of these three treatment modalities, EFT has overwhelmingly been the most effective treatment modality for PTSD—as well as chronic pain—in my clinical practice. Pre and post-SUD are routinely assessed within each session, and the treatment effects are not only longer lasting, but generalize to others sources of biopsychosocial distress in my client's lives. Please consider EFT as a formally recognized treatment modality within the APA's clinical practice PTSD guidelines. Thank you, David Brillhart, PsyD	Thank you for your comment. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews of EFT meeting these PICOTS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence.
Ann Margret Lovling (Group: TFT Malardalen)	Treatment Recommendations	I agree with Dr. Peta Stapelton's comments. There is clear and convincing evidence that EFT and Thought Field Therapy, TFT, is an effective and cost effective form of treatment for PTSD in adults. Please consider including this technique in your guidelines	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Danielle DuBois (Individual)	Treatment Recommendations	I support ACEP's comment. I agree with Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Mark Larson (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I am a veteran outpatient psychotherapist and trauma specialist.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Maria Castro (Individual)	Treatment Recommendations	I support the comment of "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" as well as the comment submitted by Professor Peta Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Laurie Booker (Individual)	Treatment Recommendations	I support Dr. Robert Schwartz, the research of Professor PETA Stapleton & ACEP's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ben Fischer (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I work in the VA and am trained in EFT (tapping) and other energy psychology methods. I have seen amazing results using EFT with my veterans and on myself. It continues to be an invaluable tool for daily stress management and addressing trauma. I also offer these skills for other staff members who are often amazed at the results. It's time to start giving EFT and energy psychology methods the credit they deserve!!!!!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joy Gandell (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group ACEP (The Association for Comprehensive Energy Psychology), and I support Professor Peta Stapleton's comment. I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Monique Verpoort (Group: ACEP)	Treatment Recommendations	I support ACEP's and Professor Peta Stapleton's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Angelina Grimaldi (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Pippa Gagie (Individual)	Treatment Recommendations	Regarding the use of EFT (Emotional Freedom Techniques) I fully support Professor Peta Stapleton's comment. Additionally, I support ACEP's comment and agree with Dr Robert Schwarz on behalf of The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see our responses to the referenced comments.
Maria Butoi (Individual)	Treatment Recommendations	I agree with the comments made by ACEP and Peta Stapleton	Thank you for your comment. Please see our responses to the referenced comments.
Saso Volcjak (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see our response to the referenced comment.
Patricia Doyle (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment.	Thank you for your comment. Please see our response to the referenced comment.
Jacqui Sansom (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology which are also supported by Dr Peta Stapleton who has undertaken a wealth of peer reviewed research and is a leading authority on these matters	Thank you for your comment. Please see our responses to the referenced comments.
Gretchen Hansen (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, as well as support Professor Peta Stapleton's comment about	Thank you for your comment. Complementary and integrative health interventions were

Commenter (Group or Individual?)	Section	Comment	Panel Response
		the efficacy of using Emotional Freedom Technique (EFT) to assist with the treatment of PTSD. This technique provides an environment in which a patient can safely explore and release the emotional impacts of trauma, opening the door to deeper, more holistic healing. EFT addresses the whole being gentle and non-invasively at a speed that can be tolerated and accepted by the patient. In addition, it pairs beautifully with cognitive therapy, addressing what cognitive therapy alone cannot. I am disappointed to see most self-regulatory practices for the treatment of PTSD deemed ineffective in this document. As stand-alone treatments, I agree they do not address all that is needed by the client. However, those suffering from severe trauma are easily triggered into fight, flight or shutdown responses. Helping them recognize what this feels like when it happens and how to be an agent in their own self-regulation should always be the goal of any treatment effort. This is as much a life skill as a skill for treatment.	identified as an area of interest by the Panel and available evidence of these interventions was considered. We would like to clarify that EFT was not deemed ineffective by the Panel. At this time, there are no systematic reviews of energy psychology approaches meeting these PICOTS criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence. Please also see our responses to the referenced comments.
Pavel Pozdnyakov (Individual)	Treatment Recommendations	I support Professor Peta Stapleton comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
K Bauer (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I fully support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

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Eda Hardy (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cathy Pavlik (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Caroline James (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Penny Snyders (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Margaret Lynch Raniere (Individual)	Treatment Recommendations	The research has shown that EFT is a highly effective treatments that often works more rapidly with similar or better outcomes compared to other gold standard treatments. EFT for PTSD has been evaluated by the Veterans Administration and has been accepted as safe and effective. Thousands of therapists use this approach and have treated tens of thousands of patients. Major medical institutions, including Kaiser Permanente and the Cleveland Clinic, utilize EFT and describe it on their websites. How can one of the most well-researched therapies in the world (more than 200 studies published in peer-reviewed journals show its	Thank you for your comment. Complementary and integrative health interventions were identified as an area of importance by the Panel and available evidence of these interventions was carefully considered. At this time, there are no systematic reviews of EFT meeting specific PICOTS criteria for inclusion in the guideline update. Thus, EFT could not be further considered. Please see above comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		effectiveness with a range of clinical conditions) not be included for evaluation in these guidelines?	
Kay Bee (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. EFT has been instrumental in my journey with PTSD treatment. I have found it to be more effective and efficient than EMDR.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Candace Fox (Individual)	Treatment Recommendations	I hugely support ACEP's comment as well as Professor Dr Peta Stapleton's comment. The research speaks for itself when looking at clinical EFT as an appropriate and effective intervention for PTSD symptomology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lada Shirokova (Individual)	Treatment Recommendations	I support Professor Peta Stapleton comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
George Limberakis, LCMHC (Individual)	Treatment Recommendations	I am a clinical mental health counselor in practice for 22 years. I am in full support of the comments made by ACEP and Peta Stapleton regarding the use of Emotional Freedom Techniques (EFT) in the treatment of PTSD. There is ample research to support its efficacy	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lisa Sussman (Individual)	Treatment Recommendations	As a clinical psychologist and APA member for close to 30 years, I am disappointed and frustrated that APA has not been seriously looking at the accumulation of sound research on EFT and incorporating EFT into APA treatment guidelines. I fully support the comments of Professor Peta Stapleton and Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology on the effectiveness of Energy Psychology and EFT in treatment of PTSD in Adults. I fully support the comments of Professor Peta Stapleton and	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	
Wade Cockburn, PhD (Individual)	Treatment Recommendations	I fully support the comments of the Association for Comprehensive Energy Psychology (ACEP), Robert Schwarz, PsyD, and Peta Stapleton, PhD. Please review the current research to add Emotional Freedom Technique (EFT) as an approved treatment for PTSD in adults.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ailish Pal (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP and I support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gail Stone (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. As a client, this work as been effective and is giving me lasting relief. Importantly for me and people like me, EFTTapping is also an effective self-help technique that can be taught remotely. People need access to this health care modality. At the very least, you need to review the extensive research.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Richard Dalke, MS (Individual)	Treatment Recommendations	I support ACEP's comment and I also agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment as well. I am a Master's level counselor (over 35 years) specializing in using EFT (Emotional Freedom Techniques) as the primary modality in treating my clients.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Crystal Sanchez (Individual)	Treatment Recommendations	I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Karin Krall (Individual)	Treatment Recommendations	I support ACEPs comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lori Hopps (Group: ACEP)	Treatment Recommendations	I am a licensed psychologist, trained in APA accredited grad programs, including internship. I follow ethical guidelines from the APA. Empirical studies supporting EFT (Emotional Freedom Techniques) as protocols for treating PTSD are described in ACEP's letter. I agree with the materials that have been submitted. Please include EFT as one of many recommended interventions in the guidelines for treating PTSD in adults.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lucinda Peyton-Jones (Group: ACEP)	Treatment Recommendations	i support all the research and comments made by Peta Stapleton, I know first hand, by using this technique how it has helped people experiencing trauma in very real terms.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Bailey Levis (Group: ACEP)	Treatment Recommendations	I agree with and support statements made by Dr. Robert Schwarz on behalf of ACEP as well as Dr. Peta Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Margaret McSherry (Individual)	Treatment Recommendations	[PASTED COMMENTS FROM ACEP]	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ilaria Novak (Individual)	Treatment Recommendations	I have used Clinical EFT successfully with clients with PTSD. I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		support Professor Peta Stapleton's comments. Please include EFT as one of many recommended interventions in the guidelines for treating PTSD in adults.	for Comprehensive Energy Psychology and Professor Stapleton above.
Lennie Kwock (Individual)	Treatment Recommendations	I support ACEP's Response to APA clinical guidelines for PTSD, particularly EFT as an effective treatment intervention for PTSD	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Micah Saviet (Individual)	Treatment Recommendations	I support ACEP's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kimberly Robbie (Individual)	Treatment Recommendations	I strongly agree with Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology! I also passionately support and back up the comments of Professor Peta Stapleton's!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Andrea Rudolph (Group: ACEP)	Treatment Recommendations	I support ACEP's comment. I have been successfully using EFT with my clients for over a decade. It's a gross oversight to exclude from treatment options.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mary NurrieStearns (Individual)	Treatment Recommendations	I support ACEP's Comment. How can you ignore research on EFT for PTSD?	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Arlene Josephson-Sauer (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comments. Please include EFT as one of many recommended interventions in the	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		guidelines for treating PTSD in adults. I have used EFT with a practitioner to successfully treat trauma in my own life.	
Kerri Husman (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church. I am a double board certified psychiatrist, treating children, adolescents, and adults, using Emotional Freedom Technique, Thought Field Therapy and Holographic Memory Resolution, with success, for the diagnosis of Post Traumatic Stress Disorder. To leave out these evidence based techniques is a great disservice to our patients.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Fliss Gray (Individual)	Treatment Recommendations	I strongly support Professor Peta Stapleton's comment. agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sarah Cleghorn (Individual)	Treatment Recommendations	I fully support Professor Peta Stapleton's comment in addition to the comment from Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Suzanne Alfandari (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comments. Clinical EFT is accepted and used in Kaiser Permanente and the VA. Please include EFT as one of many recommended interventions in the guidelines for treating PTSD in adults. It's time.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Matia Pradels (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Jessica Tulloss (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sarah Miller (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tamara Pearce (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Hilary Jones (Individual)	Treatment Recommendations	I fully support the comments made by Professor Peta Stapleton and Dr Robert Schwarz.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nancy Shea (Individual)	Treatment Recommendations	I support ACEP's comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jessica Hagel (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! Emotional Freedom Techniques (EFT Tapping) is a very powerful protocol for easing the symptoms of PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Maria Dunn (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Diane Davis (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sheri Severson (Individual)	Treatment Recommendations	First off, I fully support the post and comments made by Professor Peta Stapleton as well as Dr. Robert Schwartz on behalf of the group ACEP. Secondly, as noted in Line 1429, pg 72- It is documented that: "Research also suggests when patients engage with their preferred treatment, they may experience improvement in PTSD symptoms (Youngstrom et al., 2013). This underscores the importance of providers allowing patients to play an active role in their treatment decisions." With this being noted, it is 2024 and we are at a place in which there are quality, well established, and well-researched credible models available that do not fit into a traditional "inside the box" approach to helping clients. Therapy is not a one size fits all model in which we can expect clients to all respond to talk therapy, that overlooks the important role of the body, as it pertains to trauma work. All of the listed evidenced approved models which have been given strong support by your research body, including exposure therapy and both cognitive focused models, work with trauma at the level of thoughts only. This is not to say those models are not helpful. This is only to acknowledge that those models miss taking into consideration the whole person, mind AND body. As ongoing research has been well	Thank you for sharing your experience with EFT helping address trauma-related symptoms. Please see the response to ACEP's comments above. Lack of inclusion as a recommended treatment does not imply that a treatment is ineffective or not helpful. Simply, the evidence to date as defined by the guideline processes, does not support its inclusion at this time. We appreciate the importance of patient preference, and that therapy is not one size fits all. Multiple options of effective treatments for PTSD benefit clients. Please see also the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

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		established regarding how trauma is stored IN the body, it is imperative that we have models in place that take into consideration treating the whole human being, not just what happens in the space of their mind and thoughts. One of these holistic models is Emotional Freedom Techniques, also called tapping. Tapping works at a brain and body level to aid in processing of trauma and has extensive research backing to validate its efficacy. Following, Line 1458, pg 73. Again, referencing the document: "A lack of confidence in the value and effectiveness of PTSD treatments may affect treatment retention (Spoont et al., 2017). Approximately 25-68% of patients drop out of PTSD treatments (Garcia et al., 2011, Schnurr et al., 2007; Ghafoori et al., 2019)." This is an extremely unfortunate statistic that a significant number of clients drop out of treatment. I wonder if this is because traditional talk therapy encourages dialoging about the event and works only at the level of the brain/mind. It ignores how the body is also needing to process those traumas. If there is a well-researched modality that can offer another option for our clients, it needs to be worthy of inclusion as an accepted treatment. I would respectfully request that additional time be taken to review the growing literature that supports EFT. It would be remiss to not re-evaluate the growing and extensive research on Emotional Freedom Techniques to consider adding it as an evidenced based treatment modality for PTSD and C-PTSD.	
Tom Porpiglia (Group: ACEP)	Treatment Recommendations	I support ACEP's comments. I have been using Energy Psychology techniques, mostly Emotional Freedom Techniques (EFT or tapping), in my private practice as an	Thank you for sharing your experience with EFT helping address trauma-related symptoms. Please see the response to ACEP's comments

Commenter (Group or Individual?)	Section	Comment	Panel Response
		LMHC to treat trauma since 1998. I assisted in the research in using EFT on veterans with PTSD where we saw a average 63% reduction in symptoms in 85% of the participants. The outcomes were also sustainable over time. One of the veterans that I treated in the Veterans Stress Project recently contacted me. He was treated in 2012. The first thing he told me was that all of the issues we worked on NEVER came back. He was calling because new issues were surfacing that made him a good soldier and no longer served him. This was very rewarding for me to here. In my opinion excluding Energy Psychology Techniques, especially EFT tapping, from the treatment of PTSD is a disservice to anyone who has experienced trauma and is in need of assistance, especially if they have been through various other therapies without success.	above. Lack of inclusion as a recommended treatment does not imply that a treatment is ineffective or not helpful. Please see also the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
April Watters (Individual)	Treatment Recommendations	As a certified trauma-informed EFT provider I have seen firsthand how EFT impacts clients with PTSD. From the first session they are empowered with a tool that leads to a calmer, more secure, and hopeful mindset. Over the course of multiple sessions the impacts of EFT equips the client with a self regulation tool supporting a calmer state of being, enjoyment of life, and a renewed ability to trust. EFT aids in healing what was shattered in trauma, as well as in building resilience that may have never been built for a client as a child in the first place. EFT is a unique and gentle resource for treating PTSD that clients can use in real time when they are triggered outside of a guided session.	Thank you for sharing your experience with EFT helping address trauma-related symptoms.
Alicia Donovan (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Association for Comprehensive Energy Psychology. EFT should be included! I have worked successfully using EFT to treat PTSD in sexual assault victims and recommend its use as a safe method of working through trauma.	for Comprehensive Energy Psychology and Professor Stapleton above.
Eden McCarthy (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have experienced and witnessed firsthand how effective Clinical EFT is at treating PTSD, having lost my home in a wildfire in 2020. EMDR and talk therapy were insufficient, and it wasn't until working with a Clinical EFT practitioner that I began to truly feel safe in the world again. I hope you will include EFT as a treatment for PTSD and allow others to experience the depth of healing I achieved.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Heather Ferry (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! As a Clinical EFT practitioner I have worked with many clients who have a PTSD diagnosis and witnessed them experience significant and lasting improvements in their wellbeing.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above. Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sara Capizzi (Individual)	Treatment Recommendations	As a Clinical Psychologist, Psychotherapist and Researcher, I support Professor Peta Stapleton's comment. EFT is very effective amd powerful for treating PTSD and trauma-related symptoms, in my professional experience	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

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Siok Bee Tan (Individual)	Treatment Recommendations	The updated Clinical Practice Guideline for the Treatment of PTSD in Adults failed to include any of the research on EFT over the last 10 years. Personally I am trained in many modalities, including hypnotherapy and in my pracrice I opened that Energy Psychology such as EFT and TFT are effective for wide range of clinical issue. Do include the research evidences in this guideline.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Samantha Vigliotti (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Adele Vincent (Individual)	Treatment Recommendations	I support ACEP's comments. I strongly believe in the transformative power of clinical emotional freedom technique (cEFT) or tapping. I have used it extensively and successfully for myself for childhood trauma, anxiety, an eating disorder, and PTSD. I'm clinically diagnosed with all but the PTSD, although i believe i would have tested positive before i overcame it all. The other modalities i benefitted from in my recovery were: CBT, mindfulness-based CBT, talk psychotherapy, neuroemotional technique (NET) / kinesiology, hypnotherapy, and a long-term yoga and deep meditation and mindfulness practice. I continue to use cEFT, NET/kinesiology, and yoga/meditation/mindfulness on an ongoing basis to keep thriving in life. I have found cEFT to be enormously beneficial and extremely accessible for myself and my yoga therapy clients. Please consider the inclusion of cEFT as an approved psychotherapy by the APA. It has far-reaching potential as a tool for people to learn and self-	Thank you for sharing your lived experience with cEFT and how helpful that has been for you. Please know that lack of inclusion as a recommended treatment does not imply that an intervention is ineffective or not helpful. Simply, the evidence base to date, as defined by this process, failed to reach a threshold where it could be included. For a more detailed response, please read the response to ACEP's comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		administer to help themselves overcome their trauma and transform their lives. I am not a researcher in the field but have a PhD in neuroscience and am currently practising as a yoga therapist and have just published a children's yoga storybook called "Shout It Out! Yoga Therapy for Emotional Resilience".	
Chrystal Goldschmidt (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Christiana Roncalli (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Heather Todd (Individual)	Treatment Recommendations	I fully agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also fully agree with Professor Peta Stapleton	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Maggie Robertson (Individual)	Treatment Recommendations	I support the statement about including EFT in the clinical guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
R Kettles (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

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Alice Emmett (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lucinda Dalrymple (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! Thank you	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carmel Moore (Individual)	Treatment Recommendations	I support Professor Peta Stapelton's comment. I also agree with Dr Robert Schwarz on behalf of Group ; ACEP - the Association for Comprehensive Energy Psychology. Eft should be included. Thank you	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kim Vanderwiel (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sylvie Stuart (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Rebecca Hanson (Individual)	Treatment Recommendations	As a psychotherapist, I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. I have seen a significant shift in people using it. I have experienced shifts in myself by self-administering. Additionally, including EFT as an option for PTSD treatment may improve the availability of care in underserved areas.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
K J (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Viki Thondley (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment regarding clinical EFT and agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. The APA cannot afford to continue ignoring energy psychology and EFT and TFT, nor to ignore any of the research or meta analyses that clearly demonstrate efficacy and validity. To truly update and revise the clinical practice PTSD guidelines - originally published in 2017 and now outdated - it is more important than ever to include clinical EFT as a well-researched and utilised therapy tool within these revised guidelines to more appropriately reflect psychological interventions in the modern age.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Isabel MacLeod (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Adriana Popescu (Individual)	Treatment Recommendations	I support ACEP's comments and want to add that I quit my membership in your organization because of your obvious bias against ACEP and Energy Psychology. You continue to ignore/dismiss compelling research data that supports the efficacy of these techniques for PTSD and a number of other debilitating mental health conditions. I have used these techniques with thousands of clients and obtained far better results than with conventional therapies alone (whose	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		research, in many cases, is outdated and is surpassed in strength of results by EP research). I will not be financially supporting an organization that does not support the work that I do.	
Joann Woodard (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. Our veterans deserve to have this treatment. This treatment has been very effective for me personally in overcoming phobias.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Valerie Lafond (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Phyllis Thordarson (Individual)	Treatment Recommendations	I support the statement about including EFT in Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Vicki Allen, LCSW-C EFT-Cert. (Group: Positive Energy Transformations)	Treatment Recommendations	I am a Therapist who specializes in trauma treatment, which includes PTSD. I have great success in helping people to relieve trauma utilizing Emotional Freedom Techniques (EFT). This statement is supported by research, which has been presented to you by ACEP and Dr. Dawson Church. Emotional Freedom Techniques should be included in your guidelines.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nata Hurst (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. Have been using EFT for years. It is very helpful. Know others that have used it and had it helped them a lot.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Tarah Bigger (Individual)	Treatment Recommendations	I wholeheartedly support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kerrie Elliott (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kath Clarke (Individual)	Treatment Recommendations	In my practice, EFT is effective in similar circumstances as EMDR for PTSD but with the added benefits that (a) clients can do it on their own (eg. when panic is building) (b) it can be effective with various symptom targets (eg. beliefs or body sensations) (c) it's more effective for complex PTSD, where the traumatic memories are numerous and often implicit. As other professionals have argued and the research supports, EFT should be included. Don't let the term Energy Psychology put you off, there is a research base for it's effectiveness.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Donna Gelinas (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Robin Friedman (Individual)	Treatment Recommendations	I support ACEP's comments and Dr. Peta Stapleton's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sahana S (Individual)	Treatment Recommendations	I support ACEP's comment	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Cammie Evans (Individual)	Treatment Recommendations	Clinical EFT has quite literally saved my life. After experiencing significant trauma, I have been able to return to work as a front-line healthcare worker; this is something I did not think I would ever be able to do again. I use it with some of my patients in a healthcare setting to calm anxiety. One of my family members no longer qualifies for the diagnosis of PTSD since he participated in EFT sessions. He had previously tried DECADES of CBT, medication, hospitalizations, and more. I support ACEP's comment. I support Professor Peta Stapleton's comment.	Thank you for your comment and sharing your experience. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Francesca Christie (Individual)	Treatment Recommendations	The use of EFT enabled me to manage my PTSD and come off antidepressant medication. I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I agree with Dr Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sandy Bohn (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. EFT can be a powerful and effective treatment option for many things including PTSD	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tray P (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! A friend was raped 13 years prior by someone who just walked into her house during the night. Ever since she'd been vigilant about locking up before bed, in a way she knew was	Thank you for your comment and sharing your friend's experience. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		unhealthy. After ONE hour of tapping: She called me a few days later, " I forgot to lock my doors last night". She was stunned that it didn't even cross her mind until well into the next morning. And it has "stuck" for over 4 years now! If offering EFT BEFORE Drug Prescriptions this isn't the very definition of DUTY OF CARE, I don't know what is!	
Nicole Ivens (Individual)	Treatment Recommendations	I support professor Peta Stapleton's comment. I have also used EFT Tapping in the treatment of my own PTSD as a carer to my child with epilepsy, I am no longer triggered by her past seizures.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kseniya Feting (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jenene Richards (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have successfully resolved all PTSD trauma with EFT. My life has turned around so much I believe everyone deserves this opportunity for treatment options. I am so convinced by the science and transformational shifts that are possible.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ebru Ates (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! Eft helped me to overcome my long standing sleep deprivation and helped my son so many times to ease	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		physical pain when he got injured and many others whom I helped healing	
Gabriela Matoi (Individual)	Treatment Recommendations	I support Professor Doctor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dina Mujanovic (Individual)	Treatment Recommendations	I support Dr. Peta Stapleton and her research on EFT.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ingrid Gerrits (Individual)	Treatment Recommendations	"I support the comments posted by ACEP, Stapleton and Church." EFT is being practiced world wide because it is support by over 100 scientifically guided RCTs (Randomized Controlled Trials), it is a very gentle technique to help humanity overcome their traumas both small and big. I agree with Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" and I also support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Helen Pace (Individual)	Treatment Recommendations	I support Dr Peta Stapletons comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ainara Leunda (Individual)	Treatment Recommendations	I support Professor Peta Stapleton comments about EFT.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Sonia M (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" and I also support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Pernille Hildorf (Individual)	Treatment Recommendations	I agree with Prof. Peta Stapleton and support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Selina Merkelbach (Individual)	Treatment Recommendations	The name energy psychology for EFT might be missleading, making it sound esotherical. It is not. It is a hands on technique, backed up by many good studies. It works, and it works quickly. It works on the physical level (cortisol, HRV,...) and most important on the emotional level, facitilatiing long term change and healing from trauma. I work with EFT as a medical doctor spezialized in Rehabilitation and Psychosomatics, everyday and I see amazing success, esp with traumatized patients. It is quick and easy and safe. For me it was a gamechanger in working with patients and beeing able to help the truly heal. I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Julie Stevenson (Individual)	Treatment Recommendations	I agree with Professor Peta Stapleton's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nicole Dubruel De Broglio (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment too and any other comments that have been posted on the topic. I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment too.	for Comprehensive Energy Psychology and Professor Stapleton above.
Tamar Eyal (Individual)	Treatment Recommendations	I support ACEP's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Bettina Falkenberg (Individual)	Treatment Recommendations	As and Advanced EFT Practitioner and Trainer I have supported clients with complex PTSD for 15 years, achieving astonishing improvements often after the clients had tried other therapy forms without results. EFT is gentle, safe, fast, and cost effective. If your objective is to improve results for clients you must not ignore EFT as a possible treatment options. I support the comments of Prof Peta Stapleton of Group EFT, Dr Dawson Church of Group EFT, and Dr Robert Schwarz of Group ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tineke Hooijsma (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment" too or any other comments that have been posted on the topic.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gemma Hunt (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Amanda Wonderland (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Elena Ovsyannikova (Individual)	Treatment Recommendations	I support ACEP's comment. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alena Bondarovich (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mary White (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton, and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Candice Porter (Individual)	Treatment Recommendations	I concur with the detailed comments sent to you by ACEP, the Association for Energy Psychology regarding your plans to not include EFT as a recommended treatment for PTSD.. I carefully read their excellent description of how EFT works, how thoroughly it has been studied and the efficacy of it. I have been a psychologist practicing for forty years and specializing in trauma for the past twenty five. I have used many kinds of trauma treatment including EMDR. I have found EFT to be the quickest, most effective tool in my repertoire of skills. If you could just watch a demonstration by a skilled clinician and see the looks on clients faces when within minutes, they are smiling and laughing with relief because the emotion they were stuck in and sometimes paralyzed by is literally gone, frequently for good. I have seen patients who are terrified of EMDR and refuse to try it for years, but they use “tapping” regularly to lower their fear or	Thank you for your comment and for sharing your experience with EFT helping address trauma-related symptoms. Lack of inclusion as a recommended treatment does not imply that a treatment is ineffective or not helpful. Simply, the evidence base to date, as defined by this process, failed to reach a threshold where it could be included. Please see response to ACEP above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		panic arousal. I believe it is a great disservice to our public, to prospective new clients to treat EFT like it's a treatment outside of the norm. It's very versatile. It can be used along with other treatments and be a simple way for clients to feel empowered when they use it to fend off a panic attack, or strong waves of grief. But then it can be used for complex trauma to help desensitize the amygdala with layers of trauma as I've used it for clients who were kidnapped or raped. It breaks my heart that over and over again, ACEP shows you the excellent research and you just dismiss it . How is that evidence based treatment guidelines? Please look again at the abundant well designed studies and the reviews of studies and think of the people who will never benefit from such an effective treatment because they don't have your acknowledgment. I urge you to reconsider. Please reconsider your decision to omit EFT from your recommendations for treatment guidelines for PTSD. Counseling psychologist. Forty years in private practice. Twenty five years specializing in PTSD	
Marilu Wren (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mary-Jane Sharratt (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Roxanne Rosemire (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Katia Nishida Figueiredo (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of group ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lisa Lombard (Individual)	Treatment Recommendations	Please include recognition of evidence and practice based treatments that draw upon the knowledge of depth psychology and clinical hypnosis. With a sense of built emotional safety through the therapeutic relationship, clinical hypnosis allows a person to be more open to suggestions for change. The suggestions are co-created with the patient, to move them toward healing and improved functioning.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Noreen Barron (Individual)	Treatment Recommendations	I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Heidemarie Huber (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. By now there is a substantial body of evidence of its efficacy and safety when implemented by qualified practitioners.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joyce Griffiths (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment. EFT and energy psychology have substantial published evidence of successful	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		outcomes in PTSD in particular, and other situations in general. To keep ignoring this data deprives patients of valuable and effective treatments.	
Sally Radnor (Group: ACEP)	Treatment Recommendations	I support comments made by Dr Robert Schwarz and Prof. Peta Stapleton	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mary Henn (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kathleen Kaczor (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Rosa Walters (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
David MacKay (Individual)	Treatment Recommendations	I have practiced and taught Emotional Freedom Techniques (EFT) since 2007. I apply it to PTSD as well as many other issues. Before learning EFT, I learned and practiced many other psychotherapeutic techniques, but none was as fast and effective as EFT. I strongly recommend including EFT in the guidelines for treatment of PTSD.	Thank you for your comment and for sharing your experience with EFT helping address trauma-related symptoms.
Margaret Hux (Individual)	Treatment Recommendations	I have used emotional freedom techniques EFT tapping for client experiencing trauma including those diagnosed with	Thank you for your comment and for sharing your experience with EFT helping address

Commenter (Group or Individual?)	Section	Comment	Panel Response
		PTSD. I find it to be an important part of therapy and that the somatic component is powerful, along with supportive therapy, addressing cognitions and behaviors, and solution focussed approaches. I'm proud to say that EFT is one of the therapies prescribed by Canada's College of Registered Psychotherapists of Ontario (CRPO), my regulatory college. I support the comments submitted by ACEP, Stapleton and Church. Registered psychotherapist, Ontario, Canada	trauma-related symptoms. Please see our responses to the referenced comments.
Mirela Tripa (Group: ACEP)	Treatment Recommendations	I support ACEP's comments. I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Patricia Hodge (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton, and Church. Advanced Practice Nursing. I am a doctorally prepared nurse practitioner in psychiatry with over 30 years of experience in the field.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Florence Gans (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. I have personally seen many people who have had transformative experiences using EFT and other energy psychology modalities healed from PTSD. Additionally, I have a close friend who is a Licensed Counselor who uses EFT frequently in her practice and sees great positive results with her clients.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gunilla Hamne (Individual)	Treatment Recommendations	Since 2007 together with Doctor Carl Johnson PhD se have treated PTSD with Tapping in crisis areas, with refugees, survivors of trafi king and natural catastrophies as well as in clinical setting in Sweden.	Thank you for sharing your clinic experience with these techniques.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Gillian Morris (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Valerie Miller (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Michelle Black (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Suzanna Forest (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Grace Norton (Individual)	Treatment Recommendations	I definitely support the comments posted by ACEP, Stapleton and Church. My experience of using EFT with traumatized clients has been profound.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joanie McCann (Group: ACEP)	Treatment Recommendations	[PASTED COMMENTS FROM ACEP]. I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sejual Shah (Individual)	Treatment Recommendations	I support the comments posted by ACEP and Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Valerie Mortensen (Individual)	Treatment Recommendations	Since 1998, my life has been improved dramatically via use of Gary Craig's EFT (the Emotional Freedom Technique) and David Feinstein's tapping energy psychology and Nick Ortner's Tapping Solution. These techniques have worked for me 95% better than any psychological techniques I had used in the previous 30 years. I even lamented that I wish it had been available when I was a child , because if it had, I would have been a more successful confident and happy human being earlier in my life. Every session brings amazing results that last. I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. More than 200 clinical trials showing that its methods are effective.	Thank you for your comment. For a more detailed response, please see the response to the referenced comment. We acknowledge that there are many RCTs of energy psychology approaches for a range of mental health problems. The panel did not consider individual PTSD treatment clinical trials, to avoid potential bias, but instead reviewed a limited number of systematic reviews that met PICOTS criteria (e.g., adults, diagnosis of PTSD, etc.). Additional clinical trials of EFT, in adults with PTSD, and a systematic review that included these trials would be needed for the Panel to consider this intervention.
Eileen Love (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kathy Odom (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elisabeth Henn-Carlson (Individual)	Treatment Recommendations	I support the statements supporting including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
JO Ryan (Individual)	Treatment Recommendations	I support Peta Stapleton, the ACEP and Dr Richard Schwartz and all the research that has been done using Clinical EFT for the treatment of PTSD in adults.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Liz Boath (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's on the topic.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Debby Vajda (Individual)	Treatment Recommendations	I have enormous concern about the current approach taken in developing these guidelines, which undermines the potential for effective and diverse treatment options for PTSD. The research has shown that Emotional Freedom Techniques (EFT) is a highly effective treatment that often works more rapidly, with similar or better outcomes compared to other gold standard treatments. The updated Clinical Practice Guideline for the Treatment of PTSD in Adults failed to include any of the research on EFT over the last 10 years. Meanwhile, other approaches with far less research support were included for evaluation. This must be corrected.	Thank you for your comment. Complementary and integrative health interventions were identified as an area of importance by the Panel and available evidence of these interventions was considered.
Eric Leskowitz (Individual)	Treatment Recommendations	I worked for over 25 years as a Harvard Medical School-affiliated psychiatrist in a program for chronic pain patients. Among all the treatment options offered by our multi-disciplinary team, energy psychology (especially EFT "tapping") was most effective in eliminating the PTSD symptoms that were so often at the root of the chronic pain condition. The research literature is so extensive now that my	Thank you for your comments and for sharing your experience with EFT. It is clear that it has provided relief for many of your clients. Please see our responses to the referenced comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Harvard colleagues are impressed and welcome the use of EFT in their clinics. I hope the APA follows suit. I support the comments by ACEP, Church and Stapelton.	
Diana Conti (Group: ACEP)	Treatment Recommendations	I agree with ''Dr. Robert Schwarz on behalf of Group: ACEP - Association for Comprehensive Energy Psychology''	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anna Huff (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church. I have utilized EFT with clients experiencing PTSD with long lasting success. I have multiple clients who specifically ask for that modality to support their clinical progress and journey.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Corey Snowden (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and with Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Paola Dumet (Individual)	Treatment Recommendations	I support Dr. Robert Schwartz's comment on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, as well as that of Professor Peta Stapleton and Dr. Dawson Church. I support all the growing peer.reviewed clinical research conducted on the use of Clinical EFT and Energy Psychology for PTSD. I have personally submitted a comment and reply so you can always state "I support Professor Peta Stapleton's comment" too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Estelle Posner (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. There are many studies showing that EFT is effective for treating PTSD. Yo need to include this treatment that has been proven to	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		help. Especially when there are no negative side effects and it doesn't cost a lot.	
Denise Noblet (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Doris Ioncar (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kristan Roth (Individual)	Treatment Recommendations	As a member of both the Internal Family Systems and Polyvagal Theory communities, as well as being a Safe and Sound Protocol Provider, I often communicate with therapists. Increasingly, I've heard many of them using the Emotional Freedom Technique in their practices. As a Certified EFT Practitioner, I've both experienced and seen the benefits with so many clients. There are so many people struggling right now, and it would be beneficial to include as many interventions that can be backed by research, as has been the case with the EFT's effectiveness. I appreciate your consideration. I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment.	Thank you for your comments and for sharing your experience with EFT. It is clear that it has provided relief for many of your clients. Please see our responses to the referenced comments.
Terry Verzar (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz on behalf of group ACEP (The Association for Comprehensive Energy Psychology), and support Professor Peta Stapleton's comment as well. EFT has been well studied and is low-cost. Although I live and Practice	Thank you for your comments and for sharing your experience with EFT. It is clear that it has provided relief for many of your clients. Please

Commenter (Group or Individual?)	Section	Comment	Panel Response
		in Australia, I studied for my degree in USA and I have made many trips back there for further study. I consider myself well affiliated with APA. I have been using EFT and FEFT for some thirty years with my clients and consider it the single most effective tool I use. PTSD is a wide blanket category and I consider all trauma to have some element of PTSD. EFT has OFTEN given immediate relief from suffering to clients. The use of this modality enables clients to move forward through the major triggers to minor triggers with less abreaction and discomfort. It brings hope where there was absolutely none. Relief after thousands of dollars spent on other modalities with little effect. A major benefit of EFT is that the client can become an agent of their own healing, using EFT themselves at home or outside the clinical experience. The therapeutic alliance is still a crucial factor in treatment, however, I would consider the instillation of healthy management and control over the clients own emotional state, replacing the hallmarks of PTST, powerlessness and hopelessness, is a quality of EFT I have not found in any other modality. This often starts after the first session. I implore the readers of these comments to take note, pay attention and read further as I know my experience is not limited to my own Practice. I do believe practitioners need (at least) the basics of the field of psychology before treating severe PTSD clients. There is so much evidence based information, clinical studies and anecdotal evidence to be considered. Please consider it all.	see our responses to the referenced comments.
Ruth Hotson (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Elizabeth Scholze (Individual)	Treatment Recommendations	My life has changed dramatically as a result of EFT. A victim of cPTSD, I have been interested in the science and analysis behind why EFT is effective in treating PTSD. It is an egregious error for the APA to overlook EFT as a meaningful and efficacious modality for the treatment of PTSD and cPTSD. As someone who has personally benefited, I beg of you not to ignore meaningful results that can have positive impacts for those, like me, who suffered from trauma. Thank you. Please consider the meta analyses and other information on EFT as a useful modality for PTSD. I support the statements of Dr. Robert Schwartz and Dr. Peta Stapleton, Thank you.	Thank you for your comment and sharing your experience. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Fay Chan (Individual)	Treatment Recommendations	I support ACEP's comment, and I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Russell Cunningham (Individual)	Treatment Recommendations	"I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP." I have found EFT to be an effective treatment for PTSD, fears and phobias, grief and anger issues.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Melanie Bray (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz on behalf of group ACEP (The Association for Comprehensive Energy Psychology), and support Professor Peta Stapleton's comment as well. EFT has been well studied and is low-cost	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Lynda Scott (Individual)	Treatment Recommendations	I support ACEP's comment. I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Beatrice Anduze-Faris (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sue Mersch (Individual)	Treatment Recommendations	Dawson Church and Peta Stapleton have completed many clinical studies showing the effectiveness of emotional freedom technique (EFT) in individuals suffering from PTDS. I support Peta Stapleton's comment. Please review her studies.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kristin Miller (Group: ACEP)	Treatment Recommendations	I support ACEP's comment from Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I have been on the ACEP Humanitarian Committee for many years and with a team developed the Emotional First Aid Materials that is used in outreaches the world over. I find that that Energy Psychology regulates the PTSD somatic response in about 10 minutes and can be taught to anyone in any setting. I also find that Energy Psychology, accu-tapping in particular, is very fast, efficient, and effective in treating both Complex PTSD and Acute PTSD. I encourage the APA, to look at the comprehensive list of studies on the ACEP Research site https://www.energypsych.org/researchdb8c71b7 in order to understand the effectiveness for the treatment of PTSD. I also support the comment from Dr. Peta Stepleton who has	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		provided vast amounts of research to show the effectiveness of EFT in the treatment of PTSD.	
Katie Walker (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carmen de Bruyn (Individual)	Treatment Recommendations	As an AHPRA registered Psychologist in Australia (Australian Health Practitioner Regulation Agency) I agree with Professor Peta Stapleton and Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Naeidra Deery (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Michelle Sproule (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have worked successfully with clients who had a PTSD diagnosis. After Clinical EFT sessions, they say "I feel like I'm back to my original self again!!" which was something they didn't think was possible. Why would we restrict this option to people who have PTSD? That isn't a duty of care!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Susan Christoffelsz (Individual)	Treatment Recommendations	I support Dr Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have helped clients with PTSD using EFT. They also then have	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		a self-help tool they can use between sessions which is empowering for them.	
Sanika Tillway (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I have successfully used EFT in my work with clients with PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Loretta O'Keefe (Individual)	Treatment Recommendations	I am supporting Dr Peta Stapleton's comment, that EFT should be included. The research and findings of clinical EFT make it a tool that is an absolute essential for healing from PTSD. The science proves it. To have people heal from their PTSD is priceless; it is an unmeasurable joy and happiness to those who suffer along with their friends and family; also to the wider community. To the government?.....well do the maths.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Michael Clarke (Individual)	Treatment Recommendations	It is disappointing that you have not recognised the practice of energy psychology, Energy Freedom Technique (EFT) and Thought Field Therapy (TFT). Particularly since there is a wealth of research and meta analyses available to support these practices as both valid and effective. I support the Association for Comprehensive Energy Psychology (ACEP), in particular I agree with Dr Robert Schwartz of behalf of the ACEP. I also support comments submitted by Professor Peta Stapleton. As a lead organisation, you will be failing in your duty if you do not include Energy Freedom Technique (EFT) and Thought Field Therapy (TFT) techniques in your guidelines. Thankyou	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Christa Bates (Group: ACEP)	Treatment Recommendations	I have both experienced and seen significant positive results using EFT and recommend that the APA review and acknowledge the field of energy psychology as a valuable tool	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		to ease the suffering of people with PTSD. Even if you were to consider it as a complimentary resource it would go a long way to allow people to find and benefit from EFT. I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	for Comprehensive Energy Psychology and Professor Stapleton above.
Kimberly Roy (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Emma Gray (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment on EFT	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sharon Gorry (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alice MacKinnon (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Amanda Bos (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Leanne Mutlow (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, as well as support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sri Jay (Individual)	Treatment Recommendations	I support ACEP's comment. I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I alsi support Professor Peta Stapleton's comment. It is imperative that the comprehensive evidcen base on Clinical Emotional Freedom be considered by APS as a recognised treatment modality for PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Karen Tsai (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Rolf Kremer (Individual)	Treatment Recommendations	I support ACEP's comment and Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment"	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Bridgette Ostwald (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment" too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Bruno Sade (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Eleisha Byrne (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anne Stanley (Individual)	Treatment Recommendations	I completely support Professor Peta Stapleton's comments. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I'm an EFT Universe and EBEFT Accredited Practitioner and have worked with many PTSD cases where significant changes for the better have been achieved, eg reduction/cessation of medication; re-engagement with normal aspects of life that were not possible before. To continue to ignore energy psychology/EFT/TFT and the significant body of research supporting their effectiveness is, in my opinion, a dereliction of professional duty within the APA when so many of your membership are signing up to learn and use these techniques in their practices. It's time to realise that conventional talk therapy no longer cuts it, and do the right thing by the world population to bring relief in so many areas where these techniques can assist.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anne Leslie (Individual)	Treatment Recommendations	I totally support Professor Peta Stapleton's comments and I support Dr Robert Schwartz on behalf of the Group: ACEP - The Association for Comprehensive Energy Psychology. To continue to ignore energy psychology/EFT/TFT and the body of research demonstrating the effectiveness of these techniques is a total dereliction of professional duty with the APA. So many of your members are already trained in these techniques and are using them successfully in their practices.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		So as a professional body you have a duty of care to get up to date with proven techniques and stop denying sufferers the opportunity of relief.	
Eden Hookway-jones (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mette Rosseland (Group: ACEP)	Treatment Recommendations	I support Professor Peta Stapleton's comment and I agrer with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Rachael Tindale (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! There is an abundance of rigorous research and meta-analyses that are published in respected peer reviewed journals outlining the effectiveness of EFT, emotional freedom technique, also known as tapping, as a stress reduction tool. It creates long lasting positive change in a PTSD sufferer's life. The research cannot be ignored and EFT should be included as an essential tool to help those in need.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dr Shazia Shahzadi (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church. I have treated numerous patients with psychological disorders using Emotional Freedom Technique (EFT) and observed remarkable results in few sessions, Field of Study: psychology, speech pathology, mind and behavioral transformational specialist	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Tricialla Roache (Individual)	Treatment Recommendations	I support Professor Petta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Karyn Maguire (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Church and Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sebastian Salicru (Individual)	Treatment Recommendations	I support Dr Robert Schwartz on behalf of Group: ACEP (The Association for Comprehensive Energy Psychology). I also support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Inger Madsen (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I agree with Dr Peta Stapleton's comments too	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sharmayne Frost (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Agnieszka Kotula (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lesley Walker (Individual)	Treatment Recommendations	I support the comments of ACEP. Stapleton and Church	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Jewell Siebert (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Dr. Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tabitha Frazer (Individual)	Treatment Recommendations	support ACEP's comment. Also, I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" General Comments:Finding positive solutions for PTSD is imperative for our society.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Charlene Smart (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church Not only have I been privileged to watch many clients with PTSD change their lives, but I have also personally experienced the power of the Emotional Freedom Technique when it comes to PTSD. My son was diagnosed with Leukemia at the age of 4, and after spending 3 years on treatment, he developed PTSD. Through the years, we had taken him to many psychologists, counselors, and doctors, yet he was offered little to no help or relief. At the age of 15, he was still severely withdrawn, experiencing horrible nightmares and tremendous amounts of fear on a daily basis, but the Emotional Freedom Technique gave him his life back! He is now 19 years old, lives 600 miles away from his parents, and he is following his dreams. I know this would not have been possible without the Emotional Freedom Technique. What makes his story so concerning to me is that we were not introduced to EFT through any of those psychologists,	Thank you for your comments and for sharing your experience with EFT. It is clear that it has provided relief for many of your clients. Please see our responses to the referenced comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		counselors, or doctors. It was through my own research and stumbling on EFT Universe and Dawson Church that my child had the freedom to finally live his life! I believe by not including EFT in the Guidelines for the Treatment of PTSD, you would be continuing to do a disservice to those still struggling with PTSD. I implore you to please reconsider.	
Leanna Hunt (Individual)	Treatment Recommendations	7. Once the boxes look like this, click the pencil icon over the far right. Paste the below bolded text into the top box and click the SAVE button. I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I use Clinical EFT in the therapeutic session for PTSD on a regular basis and it is preferred by several of my clients, even over EMDR for reducing trauma symptoms	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sara Bäckelie (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Andrea Withers (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have personally healed from the traumatic effects of sexual abuse by using EFT with a certified practitioner. Not only is it fast and effective, but it is gentle and didn't leave me with secondary trauma from just bringing it up and talking about it. It literally removed the triggers so I am no longer troubled by them. I am no longer experiencing	Thank you for your comments and for sharing your experience with EFT. It is clear that it has provided relief for many of your clients. Please see our responses to the referenced comments to better understand the current limitations of the PTSD/EFT literature in regard to PTSD updated treatment guidelines.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		flashbacks and old triggers. I feel happier and lighter, and it improved my intimate relationship with my husband. Before EFT, I used to tremor internally when others told me about their abuse. Now I am a Clinical Certified EFT Practitioner myself, and I can calmly listen to my clients who have experienced abuses when they bring it up in sessions. I can and do help ground them and relieve them from the burden of their sexual and other abuses with EFT. When my clients start telling me about their abuses, I am able to use EFT to help them feel calm and safe, and let that trauma out of their bodies. Within only 60-90 minutes, they feel tremendous relief. Every session releases some aspect of the abuse. I have effectively helped them over and over again over the course of many years. It simply works, and there are studies and meta-analysis to prove it. People deserve to be helped in this safe and effective manner. Had I not experienced EFT myself over 17 years ago, I know I would be in a far different place emotionally and psychologically, and it would not be a better place. And I'm quite sure I would be incapable of helping others with all of my unprocessed trauma. Everyone deserves an opportunity to heal in this way.	
Anna Svensson (Individual)	Treatment Recommendations	I support ACEP's comment." or I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive EnergyPsychology. I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comment. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Metka Šemrl Dolenc (Individual)	Treatment Recommendations	I would like to express my concerns regarding the omission of Emotional Freedom Techniques (EFT) from the APA's current review, despite its extensive supporting evidence from over 200 published trials. This decision appears to rely on outdated assumptions about EFT's mechanisms, which are now well-aligned with contemporary psychological science and supported by multiple peer-reviewed studies. Recent discussions, such as those in the Journal of Psychotherapy Integration, highlight the scientific validity of EFT, countering critiques based on misconceptions from its early formulations. Clinical trials and meta-analyses have consistently demonstrated EFT's efficacy, particularly in treating PTSD, anxiety, and depression, with outcomes comparable to, or sometimes exceeding, those of established therapies like CBT. Notably, institutions such as the U.S. Veterans Administration and UNESCO recognize EFT's value, integrating it into policy and practice guidelines. Given the growing body of evidence, I respectfully urge the APA to reconsider its stance and include EFT as a validated psychological treatment within its guidelines. I respectfully urge the APA to reconsider the exclusion of Emotional Freedom Techniques (EFT) from its review. With over 200 supporting studies, EFT is now aligned with contemporary psychological science and has demonstrated efficacy in treating PTSD, anxiety, and depression in numerous peer-reviewed publications. Institutions such as the U.S. Veterans Administration recognize its value. I believe it is time for the APA to update its stance to reflect current	Thank you for your comment. For a more detailed response, please see above responses. We acknowledge that there are many RCTs of energy psychology approaches for a range of mental health problems. The panel did not consider individual PTSD treatment clinical trials, to avoid potential bias, but instead reviewed a limited number of systematic reviews that met PICOTS criteria (e.g., adults, diagnosis of PTSD, etc.). Additional clinical trials of EFT, in adults with PTSD, and a systematic review that included these trials would be needed for the Panel to consider this intervention.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		evidence and consider EFT as a validated psychological treatment.	
Chatelle Jeram (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cristina Saavedra (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology"	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Suzanne DeMasso (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology as well as agree with Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Debra Greene (Individual)	Treatment Recommendations	Dozens of research studies support the efficacy of Emotional Freedom Techniques (EFT) for PTSD. It is unconscionable that these techniques are left out of the APA guidelines for treatment of PTSD. Please find relevant research at Link. As a practitioner of Emotional Freedom Techniques (EFT) for more than 20 years, I can testify as to the efficacy of EFT and I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jo Black (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Michael Ryan (Individual)	Treatment Recommendations	As a seasoned mental health therapist I have used EFT/tapping effectively to treat PTSD. I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elena Lucía Peña (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology".	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jennifer Douglas (Individual)	Treatment Recommendations	I support Emotional Freedom Technique as an evidence-based approach to treating PTSD. I support the statements submitted by ACEP, Stapleton, and Church. Emotional Freedom Technique has been rigorously studied and validated with results published in peer-reviewed journals and meets the standards for an evidence-based practice for PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lena Kushnir (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Norine Burgess (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kimberly Stevens (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. As someone who has used EFT to recover from childhood CPTSD, I have personally seen and experienced how useful this method is for the treatment of PTSD, and how long lasting the	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		results are. I am an entirely different person, in the best of ways. “I support Professor Peta Stapleton's comment"	
Emily Chu (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cassandra Baldwin (Individual)	Treatment Recommendations	I have seen the benefits of remedial massage and relaxation massage in assisting PTSD patients which aids sleep and stress reduction therefore assisting with the reduction in PTSD symptoms. I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carol Hart (Individual)	Treatment Recommendations	It seems very odd that the APA guidelines for the treatment of PTSD don't mention the well-researched field of meridian tapping, or Emotional Freedom Techniques, specifically, as a treatment of choice for PTSD. This has been well documented in RCTs as well as Meta Analyses of the numerous studies done in the past many years. Please reconsider publishing these guidelines before looking at the all the evidence from this field of study and practice first, and then include it in your guidelines. To not do so would be improper and seem suspiciously like the APA has blinders on just because meridian tapping doesn't fit the regular "box" of available treatments. I support the comments submitted by the Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Patti Lott (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology Field of Study:counselling therapy	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sonja Luoto (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Andra Bassanini (Individual)	Treatment Recommendations	As a Clinical Psychologist, Psychotherapist and Researcher, I support Professor Peta Stapleton, Dawson Church and ACEP comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jamie Reineke (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jana Stocker (Individual)	Treatment Recommendations	I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elaine Bruewer (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Louise Sanders (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Deborah Ponti (Individual)	Treatment Recommendations	I support the comment of ACEP. I support the comments of Dr. Andrea Bassanini and Professor Peta Stapleton	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kerstin Claaßen (Individual)	Treatment Recommendations	"I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tatjana Walton (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr. Robert Schwarz on behalf of group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have worked successfully with clients who had a PTSD diagnosis. After clinical EFT sessions, they say things like "I can't believe how different I feel." "I feel like ME again." something they got told would not be possible. Why would we deny this opportunity to sufferers by not including it? How is that duty of care?	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Pattie Samson (Group: ACEP)	Treatment Recommendations	I support ACEP's Comments of including EFT for treatment of PTSD. I support ACEP's comment to include EFT as a recommended treatment for PTSD as supported by their submitted research. Include EFT for treatment modality	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tanja Jankovic (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" and dr Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Lesley White (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. Emotional Freedom Techniques ('EFT') should be included as approved Clinical Practice for the treatment of PTSD in adults. Failing to include practitioner-level EFT runs counter to credible recent scientific evidence and to APA's stated commitment to evidence-based practices. EFT has demonstrated significant efficacy in treating PTSD symptoms, as evidenced by multiple randomized controlled trials (RCTs) and meta-analyses. Key points: - Strong Evidence Base: EFT has been subject to over 100 clinical trials, including numerous RCTs specifically for PTSD. This robust body of research meets the APA's standards for evidence-based treatments. Rapid Symptom Reduction: Studies have shown that EFT can lead to significant reductions in PTSD symptoms in as few as 4-10 sessions. This efficiency is particularly valuable given the high demand for PTSD treatments. Long-Term Effectiveness: Follow-up studies have demonstrated that the benefits of EFT for PTSD are maintained over time, with some studies showing continued improvement even after treatment has ended. - Neurobiological Basis: Research has identified specific changes in brain function associated with EFT treatment for PTSD, providing a scientific explanation for its effectiveness. - Cost-Effectiveness: Given its rapid results and potential for group application, EFT could offer a cost-effective option for treating PTSD, especially in resource-limited settings.	Thank you for your comment and please see the response to Professor Stapleton and Dr. Schwarz on behalf of ACEP. he omission of EFT in the guidelines does not indicate that the Panel has deemed EFT to be ineffective. Prior to reviewing the evidence, the Panel set the scope of the guideline to focus on adults diagnosed with PTSD. Based on best practices for guideline development, the Panel considered evidence from systematic reviews. At this time, there are no systematic reviews including EFT meeting these criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		1. The APA's commitment to evidence-based practice should lead to the inclusion of EFT, given the substantial body of research supporting its efficacy. 2. Excluding EFT from the guidelines may deprive practitioners and patients of a valuable treatment option that has shown promise in addressing PTSD symptoms quickly and effectively. 3. Including EFT would align the APA's guidelines with other international bodies that have recognized EFT's potential in treating PTSD, such as the National Institute for Health and Care Excellence (NICE) in the UK, which has called for further research into EFT. 4. The inclusion of EFT would reflect the APA's responsiveness to emerging evidence and innovative treatments in the field of PTSD therapy. 5. Given the growing body of research on EFT, its inclusion in the guidelines would encourage further high-quality studies, potentially leading to even more effective treatments for PTSD in the future. Credible research shows that EFT is not only effective but also time-efficient, often producing results in fewer sessions compared to many traditional therapies. To exclude Clinical EFT practice (the practice used in credible scientific research and by trained practitioners - as distinct from the short hand	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		version employed by untrained lay people) would run counter to APA's stated commitment to evidence-based practices.	
Bethany Colaprete (Individual)	Treatment Recommendations	[PASTED COMMENTS FROM ACEP]	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alison Nancye (Individual)	Treatment Recommendations	I support ACEP's comment. I also agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. Furthermore, I support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Virginia Wells (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Michelle McCosker (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I agree with Dr Robert Schwartz on behalf of group: ACEP - The Association for Comprehensive Energy Psycholog	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Doug Sternes (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jessica Cove (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Peta Noblet (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! This is desperately needed for so many people and proven to help and save lives with this clinical practice. We need this to be available for as many people as possible!!!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Robin Bilazarian (Individual)	Treatment Recommendations	Robin Bilazarian, LCSW, Website: https://robineft.net, Email: RobinEFT1@gmail.com DCEP (Diplomate in Comprehensive Energy Psychology (via Energypsych.org) International Certified, Master EFT Trainer (via EFTinternational.org) Intended Use of Guideline for PTSD - Treatment Recommendation The Emotional Freedom Techniques (EFT) Tapping aka Energy Psychology I am a seasoned clinician of 45 years and have incorporated the Emotional Freedom Techniques (EFT) Tapping aka Energy Psychology for the past 27 years into mainstream mental health facilities, a medical school, and with staff at a Regional Level One Trauma Hospital. I am an author and busy international trainer of EFT. Researchers, including Dr. Robert Schwartz and Dr. Peta Stapleton, have informed you of 200 peer-reviewed published research written in English, and another 100 written in other languages whose results have been translated, including many originating from hospitals. I am grateful to the researchers, but I want to speak as a licensed clinician. My early background was Duke Medical Outpatient Clinic, and the University of North Carolina and University of Pennsylvania Graduate Schools of Social Work.	Thank you for you sharing your extensive experience with EFT and how helpful it has been for your clients. It is not within our purview for demonstrations of techniques. Please know that complementary and integrative health interventions were identified as an area of importance by the Panel and available evidence of these interventions was carefully considered. The panel focused on existing systematic reviews that utilized our PICOTS criteria. Lack of recommendation does not equate with a statement on the potentially efficacy of an intervention, solely that the evidence based as defined by a priori criteria does not show evidence of efficacy at present.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• The mechanism of EFT is to target a negative psychological thought, memory, event, emotional and or physical manifestation. • Rate the intensity of the target on a Subjective Units of Distress Scale (SUDS) • Hold that thought, emotion or physical manifestation as you pair that with relaxing, soothing, self-applied acupoints to desensitize, and release imaginal exposure image. • Re-rate the intensity using the SUDS scale and repeat until the SUDS is 2 or below. • Often the relieved client will have a spontaneous insight, a cognitive shift and talk therapy can be more productive. • Frequently the targets are similar to the hierarchical desensitization of CBT and without the pain of imaginal exposure. Here are some of my clinical journeys. Do you object to anything as gentle as EFT that has: • Calm repeated nightmares in one session—like the recurring nightmare of a stepfather forcing a client to eat his own vomit? • Quiet the physical hyperarousal of PTSD in 20 minutes—targeting the body's reactions and releasing symptoms like a racing heart, tight throat, queasy stomach, shaking and tense body to realign homeostasis?	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		• Soothe anger and irritability related to trauma within 25 minutes? • Release panic attacks, physical pain, phobias, or compulsive behaviors in a single session? • Work with veterans using only Subjective Units of Distress (SUDS) scores to release the intensity and trauma using the limited words of "whatever happened over there," thus respecting their requirement for top security confidentiality? • Avoid relying exclusively on verbal communication with trauma clients, even when their Broca's area—the brain's language and comprehension center—goes offline at the time of trauma and in session at the mere mention of their trauma? • Dismantle a deep, intrinsic fear and lack of safety within three sessions? • Give clients a self-applied regulation technique to use between sessions to combat trauma triggers on their own? • Perform "one-session wonders" to alleviate the emotional and physical dysregulation of: o Witnesses of suicide o A compulsive client who had gouged and disfigured her face so severely that McLean Hospital (Harvard-affiliated) accepted her rare case, but this behavior resolved in one EFT session, o A homebound, heavily medicated (Clozaril) paranoid schizophrenic who released her	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		lifetime fear of the auditory hallucinations/voices and started walking and shopping alone - a huge shift of her quality of life. o A first responder's disabling incapacity to work due to his on-the-job response to a car accident involving a child o A young police officer with frozen shoulder pain of a SUDS of 7 wrestling with losing his career, releasing that pain in one session SUDS 70 and that result sustained at 3-month follow-up. o Help medical students at Cooper University Hospital resolve career ending test anxiety in one session? o Debrief first responders and medical staff, using EFT Tapping Energy Psychology to release lingering bodily discomfort even after attending the CISM debriefing? Pain affects 30–50% of the world's population, fueling the opioid epidemic that often coexists with trauma. PTSD clients often present with co-existing abuse of alcohol as an attempt to manage pain or the body's uncomfortable and potentially dangerous hyperarousal. Can you? • Release physical pain in one session to aid in prevention and recovery? • Pick someone out of an audience 200 times and release their pain dramatically, if not completely?	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		I can—with EFT. • EFT works with ease and gentleness, with the only side effects of yawning or sign of moving from the overstimulated sympathetic nervous system to the sustaining parasympathetic system. • I have accomplished this in individual sessions and 200 professional workshops and conferences with audiences of 30 to 300 therapists observing. • I have combined these methods with talk therapies for 27 years stabilizing Chronic mentally ill (and training my 13 colleagues and 2 psychiatrists in EFT at the Community Mental Health Center) avoiding frequent hospitalizations and enriching confidence and self-sufficiency. • Recruited (and stayed for 14 years) to bring EFT as an effective brief therapy model, to an Employee Assistance Program at a Regional Level One Trauma Hospital and Medical school (Cooper University Hospital) treating medical staff, first responders, schools, firefighters, and police. I used these methods 3-5 times every day to reduce whatever stressors presented and ran frequent staff workshops on this for stress and pain management. • Recognize that accepted exposure therapies may be effective, but incredibly painful. EFT is an imaginal exposure and desensitizing technique that is gentle and equally effective. Probably faster, too. EFT Tapping is based on acupressure/accupressure,	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		practiced in Asia for over 5,000 years. That is a long time to survive if it is a pseudoscience and not effective. In the U.S., acupressure/acupuncture are well-regarded for pain management and EFT can be too. For example: o I worked with a workshop volunteer participant suffering from five years of intense pain after the removal of a cancerous, baseball-sized tumor. At one-year follow-up, she reported: "I don't think about pain anymore." o Here is her 25-minute live demonstration, which included both teaching and resolution. I hope you will watch it. Pain Release with Metaphors and EFT Tapping on YouTube.com: LINK o I have conducted similar live demonstrations over 200 times at workshops and conferences, with equal results with volunteers from the audience. "Body-up" techniques like EMDR, progressive muscle relaxation and breathing pair effectively with "talk down" therapies. EMDR uses bilateral stimulation, and EFT uses tapping on acupuncture points. Research has shown that EFT and EMDR appear to be similarly effective (Karatzias et al. 2011). My experience shows EFT to be gentler as it primarily has a calming effect evidenced by yawning and sighing, a sign of moving into the parasympathetic nervous system. It may	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		be quicker than Benzodiazepines. I am puzzled by any resistance to anything that calms people without medical complications in our highly stressful world. Studies have demonstrated that orphans without touch do poorly. Touch is intuitive evidence by the calming effect of hugging. Observe how we greet and soothe friends and family. Perhaps these self-applied body stimulations release the same serotonin and oxytocin response and other helpful biochemical while targeting upsetting memories. Respecting the rapid growth in psychosensory and neuroscience explanations of psychological processes include EFT. The mystery of touch, mind body tools, have shown these cognitive somatic interventions have superior results to talk therapies alone. • A skilled therapist needs both. After EFT, clients often become more open to therapeutic processing and interventions. In session, EFT can often eliminate smaller mental roadblocks in approximately 20 minutes, leaving time for integrating other therapies. • EFT is continuously rating results throughout the intervention, using the Subjective Unit of Distress Scale (SUDS). Very few interventions have a similar robust evaluation throughout the session. This guides the therapist to be as thorough as possible. • Many clients experience spontaneous insights and cognitive shifts once emotional and physical dysregulation resolves with EFT tapping. Perhaps the amygdala hijacking of the pre-front cortex is released.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		As a clinician and trainer: • I have led over 200 professional workshops in the U.S. including 5 graduate schools, and internationally (Italy, Armenia, Ukraine). My audiences are typically skeptical in the morning, attending for Continuing Education credit, then after seeing live demos of phobias, the underlying traumas and pain, they often send messages to the workshop coordinator expressing surprise. • In these settings, I select volunteers—unknown to me—from the audience and successfully release lifelong phobias and the underlying big "T" and small "T" traumas that fuel these phobias. Later in these same workshops, I demonstrate the process again for pain release with another participant. It is fascinating that adding the language of metaphors and strong emotions, (often anger) speeds up the process. I am baffled how anyone could exclude a calming, gentle, desensitization and imaginal exposure technique that works almost every time. We are on the brink of neurological understanding how this and other psychological methods work including neuroplasticity. Particularly with trauma, these gentle mind-body therapeutic techniques have the capacity to quiet recurring nightmares, calm physical and emotional agitation, dysregulation, and hyperarousal. They can interrupt the behavior, and the pre-thoughts involved in self-destructive behavior. They can release pain, a contributor to dual	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		diagnosis, co-existing complexities and neutralize recurrent intrusive memories. I welcome an opportunity to demonstrate this live to the committee as a clinician and to be partnered with an EFT researcher who could explain the research. Thank you for your reconsideration of this important well-researched and highly effective addition to clinical excellence in a highly traumatized world. Here is a video of using EFT for Veterans with PTSD. Four Case Studies of Veterans – exerted from EFT for War Veterans on youtube.com: LINK	
Antje Martens-Obewrwelland (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lis Simpson (Individual)	Treatment Recommendations	I support Peta Stapleton's comment. I support the comment made by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anna Candler (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mahima Gupta (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Barb Dyment (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. Emotional Freedom Techniques aka "EFT" should be included as approved Clinical Practice for the treatment of PTSD in adults.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
David Rosenberg (Individual)	Treatment Recommendations	As a professor and licensed clinical psychologist with over 30 years of teaching and clinical experience, it is beyond my comprehension how the APA has apparently ignored the robust evidence base supporting the use of Emotional Freedom Techniques (EFT) as a treatment option for PTSD in adults. As a trained practitioner, I have successfully utilized EFT as part of a wider holistic and integrative approach in my work with clients suffering from PTSD. I also fully support the comments that have been posted in this regard by the Association of Comprehensive Energy Psychology (ACEP), Stapleton & Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Janet Cormick (Individual)	Treatment Recommendations	I support Professor Peta Stapletons comments. EFT energy psychology should be included as a recommended treatment option, the research emphatically supports this.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Margaret Lambert (Individual)	Treatment Recommendations	I have worked as a Psychologist for nearly 20 years, and as a Trauma Counsellor previously. My roles were primarily responding to trauma related to the death of a child and also to sexual assault survivors. By far the most useful modality was EFT (Emotional Freedom Techniques), or Tapping. In almost all cases, EFT had a calming effect on patients, that facilitated the work of healing and integration of the trauma. The contexts in which I have used EFT for PTSD include prison,	Thank you for sharing your experience with EFT/Energy Psychology helping address trauma-related symptoms.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		rehabilitation centre, indigenous communities, hospitals, urban and rural clinics, and schools. I strongly recommend including EFT as a recommended treatment for PTSD. Because of the positive effects of using EFT with patients across a wide range of issues, cultural backgrounds, and contexts, I conducted a PhD research, investigating the effects of EFT on anxiety and wellbeing in primary/elementary school students. The research was a mixed methods study and showed positive effects in 72% of students, with reduced anxiety and physical discomfort and increased focus and concentration on their school work. There are now hundreds of studies, including RCT's, that show the efficacy of EFT across a range of issues, including trauma. I also work as a Supervisor for other professionals, who have reported the positive effects of using EFT with their patients/clients.	
Jacqueline Davies (Individual)	Treatment Recommendations	I support ACEP's Comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Natalie Selway (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cate Harding (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Edouard Vassiliev (Individual)	Treatment Recommendations	I support Professor Peta Stapletons comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Amber Hubka Cook (Individual)	Treatment Recommendations	I also support Professor Peta Stapleton's comment. With hundreds of studies done with Energy Psychology, EFT, and TFT that have proven to be beneficial for numerous issues and in particular PTSD. It has been proven to be as effective, if not more effective than EMDR. With it's repeated results and repeatable process, Clinical EFT, TFT and Energy Psychology should be included as an effective method of treatment. If you take a look at Dawson Church's research, you will also see these results and he has spent a considerable amount of time on PTSD specifically. If the main focus of the American Psychology Association is to help people, these treatments should be examined and included. Thank you. I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. With hundreds of studies done with Energy Psychology, EFT, and TFT that have proven to be beneficial for numerous issues and in particular PTSD. It has been proven to be as effective, if not more effective than EMDR. With it's repeated results and repeatable process, Clinical EFT, TFT and Energy Psychology should be included as an effective method of treatment. If you take a look at Dawson Church's research, you will also see these results and he has spent a considerable amount of time on PTSD specifically. If the main focus of the American	Thank you for your comment. Please see our responses to the referenced comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Psychology Association is to help people, these treatments should be examined and included. Thank you.	
Alison Quinn (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tanja Blinkhorn (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology I support Professor Peta Stapleton's comment, too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Laurel Spindel (Individual)	Treatment Recommendations	The committee has introduced bias towards those treatments which happen to be the most studied, rather than those that have been found to be most effective. The approach taken in developing this guideline predetermined the exclusion of psychodynamic psychotherapy, thus undercutting the use of a valuable and widely utilized clinical approach to PTSD. Humans are complex and individual. Please don't provide guidelines based on what feels most simplistic and least expensive for insurance companies. If you allow for modalities that put an emphasis on the relationship and deep work, I think you will find that more people get helped by being able to access what they need rather than what seems easiest to approve.	Thank you for your comments. We would like to clarify that it was not predetermined that psychodynamic psychotherapy would be excluded. We agree that human beings are complex and there are a number of clinical approaches that can be helpful for addressing PTSD. Not being recommended in the guidelines does not mean that an intervention is not effective in treating PTSD; simply the evidence base as defined by pre-determined processes and criteria did not raise the level of recommendation.
Lara Costa (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Del Smith (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nicholle Cooke-Hayes (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT is a invaluable technique and tool to help people living with PTSD. Without a doubt in my mind, EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Pamela Altaffer (Individual)	Treatment Recommendations	I support ACEP'S comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Felicity Albrecht (Individual)	Treatment Recommendations	I endorse Prof. Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I believe not including EFT in recommended treatment options for PTSD is negligent. The research is strong and demonstrates effectiveness, with minimal risk of re-traumatisation. This is an intervention that I would want available and approved for myself and for loved ones should PTSD be an issue. It is humane, effective, proven and, above all, safe and gentle. Clinical EFT should be recommended as a gold standard treatment option for PTSD. I hope the committee will review the research and decide accordingly. Thank you.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
James Robinson (Group: ACEP)	Treatment Recommendations	I whole heartedly support Professor Peta Stapleton's comment and agree with Dr Robert Schwarz on behalf of	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Group: ACEP - The Association for Comprehensive Energy Psychology	for Comprehensive Energy Psychology and Professor Stapleton above.
Gregory Brown (Individual)	Treatment Recommendations	I support ACEP's comment and fully agree with Dr. Robert Schwartz on behalf of Group: ACEP: The association for comprehensive energy psychology. I also fully endorse Dr. Peta Stapleton's Comment as well. EP techniques demonstrate amazing and quick results with patients, as I have observed on many occasions. The blind belief in CBT as a cure all is seriously harming psychology as a whole.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Melissa Hankins, MD (Individual)	Treatment Recommendations	As a psychiatrist, I have utilized EFT with very good effect for many patients with PTSD, with significant and permanent reduction in PTSD symptoms. EFT has been a modality many patients have appreciated using, particularly those for whom other therapeutic modalities (including CBT and EMDR along with medication) have not always been successful in fully managing and/or reducing symptoms. I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lisa Gumieniuk (Individual)	Treatment Recommendations	I support ACEP's comment. I also I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gun Meskanen Hopkins (Individual)	Treatment Recommendations	I support professor peta stabletons comment. I also agree with dr Robert Schwarz on behalf of Group ACEP - The Association for comprehensive energy psychology. EFT should	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		be included. I have worked successfully with clients diagnosed with PTSD using clinical EFT. Using PCL5 assessment tool they no longer met the criteria of their diagnosis. Also had comments like “I feel like my self again” and “I am not on the edge all the time”. Something they thought was impossible after been told their condition was chronic. Why would they be denied this opportunity to healing by not including EFT. How is that duty of car and following the first rule “do no harm”.	for Comprehensive Energy Psychology and Professor Stapleton above.
Louise Smith (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. Emotional Freedom Techniques ('EFT') should be included as approved Clinical Practice for the treatment of PTSD in adults. Failing to include practitioner-level EFT runs counter to credible recent scientific evidence and to APA's stated commitment to evidence-based practices. EFT has demonstrated significant efficacy in treating PTSD symptoms, as evidenced by multiple randomized controlled trials (RCTs) and meta-analyses. Key points: - Strong Evidence Base: EFT has been subject to over 100 clinical trials, including numerous RCTs specifically for PTSD. This robust body of research meets the APA's standards for evidence-based treatments. Rapid Symptom Reduction: Studies have shown that EFT can lead to significant reductions in PTSD symptoms in as few as 4-10 sessions. This efficiency is particularly valuable given the high demand for PTSD treatments. Long-Term Effectiveness: Follow-up studies have demonstrated that the benefits of EFT for PTSD are maintained over time, with some studies showing continued	Thank you for your comment. Please also see our responses to the referenced comments. Complementary and integrative health interventions were identified as an area of importance by the Panel and available evidence of these interventions was considered. We would like to clarify that EFT was not deemed ineffective by the Panel. At this time, there are no systematic reviews of energy psychology approaches meeting specific PICOTS inclusion criteria. Thus, EFT could not be considered. There may be many therapeutic approaches, including EFT, that are helpful for addressing PTSD, but do not, at present, have sufficient scientific evidence as defined by criteria for inclusion.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		improvement even after treatment has ended. - Neurobiological Basis: Research has identified specific changes in brain function associated with EFT treatment for PTSD, providing a scientific explanation for its effectiveness. - Cost-Effectiveness: Given its rapid results and potential for group application, EFT could offer a cost-effective option for treating PTSD, especially in resource-limited settings. 1. The APA's commitment to evidence-based practice should lead to the inclusion of EFT, given the substantial body of research supporting its efficacy. 2. Excluding EFT from the guidelines may deprive practitioners and patients of a valuable treatment option that has shown promise in addressing PTSD symptoms quickly and effectively. 3. Including EFT would align the APA's guidelines with other international bodies that have recognized EFT's potential in treating PTSD, such as the National Institute for Health and Care Excellence (NICE) in the UK, which has called for further research into EFT. 4. The inclusion of EFT would reflect the APA's responsiveness to emerging evidence and innovative treatments in the field of PTSD therapy. 5. Given the growing body of research on EFT, its inclusion in the guidelines would encourage further high-quality studies, potentially leading to even more effective treatments for PTSD in the future. The research shows that EFT is not only effective but also time-efficient, often producing results in fewer sessions compared to many traditional therapies. To exclude Clinical EFT practice (the practice used in credible scientific research and by trained practitioners) - as distinct from the short hand	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		version employed by untrained lay people - runs counter to APA's stated commitment to evidence-based practices. Sent	
Cathy M (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz pm behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Judita Jurašeková Kucserová (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Melody Lovell (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Andrea Herzog (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Briony Cole (Individual)	Treatment Recommendations	"I support ACEP's comment.”	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kathy Adams (Individual)	Treatment Recommendations	I support ACEP's comment.” or I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Jane Tucker (Individual)	Treatment Recommendations	I support PsiAN's comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carin Lozano (Individual)	Treatment Recommendations	I support ACEP´s comment. I also support Professor Peta Stapleton´s comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mirjana Bevanda (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". “I support Professor Peta Stapleton's comment"	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Donna Garratty (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive EnergyPsychology"	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Noelle Taylor (Group: Transformative EFT)	Treatment Recommendations	I support and endorse: - • Dr. Richard Schwartz comments of behalf of ACEP (The Association for Comprehensive Energy Psychology) • Dr. Peta Stapleton’s comments on behalf of Bond University and Evidence-Based EFT, and those of • Dawson Church on behalf of the National Institute of Integrative Health EFT is such an effective, evidence-based treatment for PTSD, it’s omission from APA’s Clinical Guidelines for the Treatment of Post Traumatic Stress Disorder for Adults, would seem a travesty.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Irena Barton (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Svetlana Todorova (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment on EFT.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Violeta Dimitrova (Individual)	Treatment Recommendations	I support professor Peta Stapleton comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Veselin Ivanov (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lucie Monroe (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elizabeth Cester (Individual)	Treatment Recommendations	I fully support Professor Peta Stapleton's comment. Additionally, I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT (Emotional Freedom Techniques) should absolutely be included. I believe you would be doing a disservice to people who are suffering with PTSD, and all those in the future, by excluding EFT from the Treatment Guideline.	Thank you for your comment. Please see responses above to the referenced comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Lubna S Qazi (Individual)	Treatment Recommendations	As a Certified Clinical EFT (Emotional Freedom Techniques) practitioner, I strongly advocate for the inclusion of EFT in APA's Clinical Practice Guidelines for PTSD treatment. The extensive body of research on EFT, including meta-analyses and randomized controlled trials, demonstrates its efficacy in reducing PTSD symptoms, improving emotional regulation, and enhancing overall well-being. Studies, such as those led by Dr. Peta Stapleton and ACEP, provide robust evidence of EFT's effectiveness as a trauma-focused intervention. Integrating EFT into the guideline would reflect APA's commitment to contextualized science that honors diverse methodologies and lived experiences. EFT is not only evidence-based but also client-centered, making it accessible to a wide range of populations, including those who may face barriers to traditional therapies. Moreover, by acknowledging EFT's contributions, APA would align itself with its stated mission to incorporate diverse, innovative, and scientifically backed interventions. This inclusion would encourage health professionals to consider a broader spectrum of treatment options, ultimately leading to improved outcomes for PTSD patients. Thank you for the opportunity to provide feedback. I support the comments made by Dr. Robert Schwarz on behalf of ACEP and Professor Peta Stapleton and urge APA to consider the integration of EFT in the final guidelines. Lubna S Qazi	Thank you for sharing your experience with EFT/Energy Psychology helping address trauma-related symptoms. Please see responses above to the referenced comments.
Deyana Racheva (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Biserka Valcheva (Individual)	Treatment Recommendations	I support Professor Peta Stapletons comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gergana Radovich (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Emille Boland (Individual)	Treatment Recommendations	I support ACEP's comment." & I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I support Professor Peta Stapleton's comments also	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Saranya Shanthakumar (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment on EFT	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Chance Eaton (Individual)	Treatment Recommendations	I support the comments and body of research posted by ACEP, Stapelton, and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tatyana Todorova (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Despina Gigova (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Lisa Irwin (Individual)	Treatment Recommendations	I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Michelle Milton (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and fully support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elizabeth Pace (Group: ACEP)	Treatment Recommendations	It is the job of APA to review research on effectiveness of novel treatment modalities, not to dismiss them without further consideration based upon bias. Our job is to follow the research and ask better questions. If energy psychology modalities are showing clinically significant results in the treatment of PTSD, then the APA should consider a provisional recommendation of EFT and other EP modalities, as they have done with EMDR. I agree with Dr. Peta Stapleton's comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jayalekshmi S (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Christine Hunt (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church. In addition, I am a certified EFT practitioner and have worked with a number of veterans, some with combat experience. Their memories and behaviors were consistent with PTSD symptoms. After just a one hour session, with each	Thank you for sharing your experience with EFT/Energy Psychology helping address trauma-related symptoms. Please see responses above to the referenced comments.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		of them, their emotional response to the combat memories was reduced from high level SUDs to very low levels, and they could recall the memories with little if any negative emotional reactions. Their reaction to the speed and depth of emotional resolution was extremely positive. They were amazed at, and almost at a loss at understanding, how quickly and thoroughly their symptoms were released. I have been a certified EFT practitioner for over 10 years and can attest to the rapid effectiveness of EFT on a wide range of personal dramas and traumas such as grief/loss, fear, anger, childhood distressors and more. I strongly support including EFT in the guidelines for the treatment of PTSD.	
CJ Puotinen (Individual)	Treatment Recommendations	I strongly support ACEP's recommendations regarding the use of EFT (Emotional Freedom Techniques) in the treatment of PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Krzysztof Goljanek (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cheryl Shepherd (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kornelia Szecsi (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I experienced great benefits by going through	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		the processes of EFT. For sufferers it would be a great advantage to have access to Clinical EFT sessions! I would love to see EFT being thought to patients as a basic tool on the path to recovery!	for Comprehensive Energy Psychology and Professor Stapleton above.
M H (Individual)	Treatment Recommendations	"I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP."	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Zecharia Sarette (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Michele Griffin (Individual)	Treatment Recommendations	"I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP." In my experience using EFT I found that it was 100% successful in treating and healing my PTSD	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Inna Alper (Individual)	Treatment Recommendations	I support ACEP's comment. I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I support Professor Peta Stapleton's comment! I am a tapping practitioner, and tapping works amazingly when treating trauma and PTSD! Sometimes one session could be enough to make huge changes in person's wellbeing!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kathleen Panela-Séguin (Individual)	Treatment Recommendations	I support ACEP's comment.I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		comment. I'm a registered psychotherapist who uses EFT with clients who have experienced PTSD symptoms. I have observed that EFT is an effective tool in assisting my clients to feel better and better emotionally, mentally, physically and spiritually.	for Comprehensive Energy Psychology and Professor Stapleton above.
Lisa Colak (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Caroline Fisher (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ramona Clifton (Individual)	Treatment Recommendations	I support ACEP's [Association for Comprehensive Energy Psychology] response, which I have copied below. As an LCSW in practice for over 20 years, EFT tapping is a valuable and effective method that I have studied and incorporated for treatment of trauma/PTSD. It is especially helpful in targeting intrusive thoughts and reducing the intensity and reactivity around traumatic memories. As the ACEP comment describes, EFT "aligns with the core principles of Acceptance and Commitment Therapy (ACT), particularly the reduction of emotional avoidance, which is a key component of healing from trauma and psychological distress." The somatic component of tapping is used in conjunction with other therapeutic methods, and the feedback and results reported by my clients has reinforced my choice of using this method, in addition to the extensive research which is detailed below.	Thank you for sharing your experience with EFT/Energy Psychology helping address trauma-related symptoms. Please see responses above to the referenced comment.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		I urge you to review the updated research on EFT and TFT, and include these highly effective interventions in the updated PTSD guidelines. [PASTED COMMENTS FROM ACEP] Ramona Clifton, LCSW-R Brooklyn, NY	
Alix Moore (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Monica McDowell (Individual)	Treatment Recommendations	I myself have taught EFT to many members of the APA who have found it an invaluable tool for themselves and their clients. Omitting a tool that has broad acceptance and the clinical testing to prove its usefulness and validity would be negligent.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Anete Hildebrante (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. EFT works for PTSD. I've used it personally and the results were incredible.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Terri Mayekar (Individual)	Treatment Recommendations	I support the statement about including EFT in the General Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Julie (Group: ACEP)	Treatment Recommendations	As a member of ACEP for almost 20 years, I have often read the research and observed the positive effects of EFT on an ongoing basis. I fully support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Deborah Steinle (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, as well as Professor Peta Stapleton's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sarah Bartlett (Individual)	Treatment Recommendations	"I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I also agree with Dr Peta Stapleton's comments. It would be very remiss and illogical for EFT not to be incorporated into and accepted as part of this document/guideline going forward. There is numerous research studies and metanalysis together with the people around the world getting relief through using EFT both for themselves and with trained Practitioners who have not had success with other more traditional modalities. As a Practitioner I often have clients who have done talk therapy for years with little relief or success and with whom sucess comes readily using EFT.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Henrik Friman (Individual)	Treatment Recommendations	My name is Henrik Friman and I work as a clinical psychologist with PTSD and complex PTSD. My experience is that EFT tapping-protocols are very useful with this population for processing trauma memories and helping them regulate arousal and affect. Therefore I agree with dr Robert Schwartz comment on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology".	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Chloe McCracken (Individual)	Treatment Recommendations	I agree with the comment from Dr. Peta Stapleton, a professor and researcher. There is a growing and respectable	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		body of evidence for the use of acupressure tapping with PTSD suffers. This should be noted.	for Comprehensive Energy Psychology and Professor Stapleton above.
Deborah Morton (Individual)	Treatment Recommendations	:I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! You completely ignore energy psychology and EFT and TFT and do not include any of the research or meta analyses. Which begs the question, how much financial interest do at least some of your members have in the pharmaceutical industry? EFT is effective for so much. If you really care about the people you are proposing to help, you will include this information because it puts another useful tool in the toolkit.	Thank you for your comment. Please see our responses to the referenced comments.
Sylvia Teteris (Individual)	Treatment Recommendations	EFT can be very effective in dealing with PTSD. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
April Boykin (Individual)	Treatment Recommendations	I have been using EFT/Energy Psychology for more than 12 years and have witnessed the effective management of trauma symptomology.	Thank you for sharing your experience with EFT/Energy Psychology helping address trauma-related symptoms.
Ann Dunnewold (Individual)	Treatment Recommendations	It is a grievous omission that Emotional Freedom Technique (EFT) is not mentioned in these guidelines. By this omission, APA overlooks a robust body of research and clinical evidence about the efficacy of this technique, meaning many PTSD sufferers will not have access to this effective treatment modality. I have used this technique successfully with multiple clients over the last ten years, and it is time for APA to wake up to the reality represented in research and clinical	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		practice. I support the comments of ACEP, Stapleton, and Church.	
Ming Xiang (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Susan Powell (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. I have used EFT personally and with others for over 20 years and have witnessed profound and lasting changes with this modality.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Virginia Lee Holmes-Hui (Individual)	Treatment Recommendations	There are over 200 clinical studies showing the effectiveness of EFT for psychological mental health support in PTSD patients. To suppress EFT as a modality in our mental health arena is keeping the population sick and controlled. EMDR is recognized in psychology world and EFT should be too. As well as MAP and EEM. EEM healed my MCAS and panic attacks. Please stop suppressing what actually heals. Big Pharma is not the only answer (and yes, I am a pharmacist). Pharm.D., EEM-CLP (Eden Energy Medicine Clinical Practitioner), MAP Coach (Dr. Garry A. Flint's work, The Process Healing Method, guiding the subconscious mind to neutralize negative emotions).	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alina Frank (Individual)	Treatment Recommendations	I shocks me to see that EFT is being omitted and is not mentioned in these guidelines. By this omission, the APA is dismissing a significant amount of research and clinical evidence about the efficacy of EFT with relation to the treatment of trauma and PTSD. Numerous RCTs and meta	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		analyses are simply being ignore because of bias. Other approaches are being included with a far less robust body of evidence. By not including this technique, many PTSD sufferers will not have access to this effective treatment option. I support the comments of Drs Peta Stapleton, Dawson Church and Robert Schwarz and Shoshana Garfield	
Cushla Sheridan (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carrie Shephard (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Puja Kanth (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Gina Madeo (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Debbie Radowicz (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Brad Reed (Individual)	Treatment Recommendations	I agree with "Dr. Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Stephenie Farrell (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Judy Ross (Individual)	Treatment Recommendations	As an Occupational Therapist working with a wide range of people, I strongly support the comments made by Professor Peta Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sarina Coventry (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Brian Rohr (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
O M (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dr Vandana Bhasin (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment that Emotional Freedom Technique can be used for PTSD. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		for Comprehensive Energy Psychology. EFT should be included!	for Comprehensive Energy Psychology and Professor Stapleton above.
Lucy Roberts (Individual)	Treatment Recommendations	EFT has been proven to be effective for PTSD in a number of clinical trials. Please take note of the detailed responses from Dr Robert Schwartz of ACEP and Dr Peta Stapleton. The most experienced clinicians I've worked with have found EFT's gentle approach particularly valuable and accessible for clients when compared to other methods such as EMDR. People who are struggling deserve to have access to as many effective methods of treatment for PTSD as possible.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Helena Zakelj (Individual)	Treatment Recommendations	"I support Professor Peta Stapleton's comment" too or any other comments that have been posted on the topic.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Trudi Ross (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included. I have worked with people who have suffered PTSD and seen notable shifts in their entire being and see a "hope" for life again when they had tried so many other things, also this modality offers them to work on themselves when they are not able to get to a practitioner deeming this an incredible life saving tool, why would you not consider this as an urgent duty of care for people and not include this	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nichole Chegwyn (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of group ACEP. I also support Dr Peta Stapleton's comment. And thirdly would like to comment on my own personal experience addressing some work aquired PTSD with clinical EFT. My work covered	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		10 sessions with a clinical EFT practitioner and my health/burnout improved dramatically as my PTSD was processed using EFT over these 10 sessions. Outstanding result and no longer have PTSD.	
Gai Smith (Individual)	Treatment Recommendations	treatment recommendations complimentary therapies	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Brisa Kotterer (Individual)	Treatment Recommendations	I wholeheartedly support Dr Peta Stapleton's comments and I agree with Dr. Robert Schwarz on behalf of group: ACEP - The Association for Comprehensive Energy Psychology. EFT should absolutely be included! There is so much evidence for EFT's efficacy that it would be a waste not to include this method in your guidelines! So many people struggling with PTSD would benefit if EFT is mentioned and credited. I myself and several other colleagues that I personally know of, have achieved wonderful results with their clients. Plus there is solid research available. It is time to take EFT out of the realm of 'woo-woo' psychology, where it doesn't belong.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alison Joan Mann (Individual)	Treatment Recommendations	I support ACEP's comments. I support Professor Peta Stapleton's comments	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Antonia Pfeiffer (Individual)	Treatment Recommendations	I would like to echo ACEPs, Dawson Church`s and Peta Stapleton's statement on Emotional Freedom Techniques and add a short statement myself. I am a medical doctor and scientist and conducted, together with my supervisors, I the first neuroscientific study on tapping techniques (like the	Thank you for your response. Please see our responses to the referenced comments. We also appreciate you sharing the additional literature. The guidelines were based on existing systematic reviews and did not

Commenter (Group or Individual?)	Section	Comment	Panel Response
		American technique Emotional Freedom Techniques) as part of my dissertation(Wittfoth et al., 2020, 2022). In this context, I investigated possible effect mechanisms of tapping that go beyond an energetic hypothesis. I looked at tapping as a possible strategy to improve exposure, which for neuroscientific reasons often does not work well in people with PTSD: Exposure depends on the ventromedial prefrontal cortex being activated during stimulus confrontation. This area is often dysfunctional in PTSD(Delgado et al., 2016; Giustino & Maren, 2018; Milad et al., 2005; Wen et al., 2022).. The task of my dissertation was to investigate tapping techniques as a possible alternative to exposure. Initial studies have shown that these are extremely effective. Looking at tapping techniques from this perspective led me to many interesting insights: - the movement during tapping could avoid a shutdown/immobilisation in the trauma confrontation. - when tapping on the skin of the face, we automatically activate the parasympathetic nervous system via the common nucleus of the vagus nerve and trigeminal nerve. Electrical trigeminal stimulation has therefore been the subject of initial pilot studies as an alternative treatment for PTSD and depression for several years (Kong et al., 2018). - Tapping on the skin of the face during stimulus confrontation is therefore similar to electrical vagus stimulation during exposure. This method has been researched for several years with the aim of improving exposure therapy(Noble et al., 2017) - The tapping protocol is similar to the reconsolidation blockade protocol, which has been researched as a treatment option for trauma memories since 2000(Feinstein, 2019). I	systematically review individual trials or studies. The Panel did not consider the hypothesized mechanisms of EFT or make any determinations for inclusion/exclusion on this basis.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		therefore endorse my colleagues' request to reconsider the inclusion of EFT as a possible treatment option for PTSD. (Arvis et al., 2021) Literature Delgado, M. R., Beer, J. S., Fellows, L. K., Huettel, S. A., Platt, M. L., Quirk, G. J., & Schiller, D. (2016). Viewpoints: Dialogues on the functional role of the ventromedial prefrontal cortex. Nature Neuroscience, 19(12), 1545–1552. https://doi.org/10.1038/nn.4438 Feinstein, D. (2019). Energy psychology: Efficacy, speed, mechanisms. EXPLORE, 15(5), 340–351. https://doi.org/10.1016/j.explore.2018.11.003 Giustino, T. F., & Maren, S. (2018). Noradrenergic Modulation of Fear Conditioning and Extinction. Frontiers in Behavioral Neuroscience, 12, 43. https://doi.org/10.3389/fnbeh.2018.00043 Kong, J., Fang, J., Park, J., Li, S., & Rong, P. (2018). Treating Depression with Transcutaneous Auricular Vagus Nerve Stimulation: State of the Art and Future Perspectives. Frontiers in Psychiatry, 9, 20. https://doi.org/10.3389/fpsyt.2018.00020 Milad, M. R., Quinn, B. T., Pitman, R. K., Orr, S. P., Fischl, B., & Rauch, S. L. (2005). Thickness of ventromedial prefrontal cortex in humans is correlated with extinction memory. Proceedings of the National Academy of Sciences, 102(30), 10706–10711. https://doi.org/10.1073/pnas.0502441102 Noble, L. J., Gonzalez, I. J., Meruva, V. B., Callahan, K. A., Belfort, B. D., Ramanathan, K. R., Meyers, E., Kilgard, M. P., Rennaker, R. L., & McIntyre, C. K. (2017). Effects of vagus nerve stimulation on extinction of conditioned fear and post-traumatic stress disorder symptoms in rats. Translational Psychiatry, 7(8), e1217. https://doi.org/10.1038/tp.2017.191 Wen, Z., Seo, J.,	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Pace-Schott, E. F., & Milad, M. R. (2022). Abnormal dynamic functional connectivity during fear extinction learning in PTSD and anxiety disorders. Molecular Psychiatry, 27(4), 2216–2224. https://doi.org/10.1038/s41380-022-01462-5 Wittfoth, D., Beise, J., Manuel, J., Bohne, M., & Wittfoth, M. (2022). Bifocal emotion regulation through acupoint tapping in fear of flying. NeuroImage: Clinical, 34, 102996. https://doi.org/10.1016/j.nicl.2022.102996 Wittfoth, D., Pfeiffer, A., Bohne, M., Lanfermann, H., & Wittfoth, M. (2020). Emotion regulation through bifocal processing of fear inducing and disgust inducing stimuli. BMC Neuroscience, 21(1), 47. https://doi.org/10.1186/s12868-020-00597-x	
Jennie Warner (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment. I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kim Fafard Campbell (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Brenda Blair (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Marie Rix (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Louise Bugeja (Individual)	Treatment Recommendations	I am also an EFT advanced practitioner, and I support the comments made by ACEP, Stapeleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Itziar Navaridas (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Emily Wildi-Curtiss (Individual)	Treatment Recommendations	I support the statement about including EFT in the clinical guidelines for treating PSTD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Danielle Crowell (Individual)	Treatment Recommendations	I support professor Stapelton's comment. I also agree with Dr. Robert Schwartz on behalf of Group ACEP- The Association for Comprehensive Energy Psychology- EFT should be included! I have successfully worked with clients who have a trauma background and seen results in their ability to emotionally regulate better and to think more clearly about their emotions and situations. I have seen decreased impulsivity, increased distress tolerance, and increased capacity for honest self reflection and healthier decision making. Not to mention seeing prominent somatic results in clients relaxation responses. In short- I've seen it build resilience, coping, and overall outlook in people I've worked with. It is a qualified modality and should be categorized as the legitimate approach that it is.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Nancy Brooker (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment as well.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Shawna Mantey (Individual)	Treatment Recommendations	As a child or a Vietnam Veteran with PTSD, I understand the importance of getting people the support they need to manage PTSD. Not only is the individual with PTSD affected, but so are their partners and children. No one thing helps all, so the more proven techniques (of which EFT is one - there are more than 200 clinical trials showing that its methods are effective) we have listed, the better off everyone with PTSD (or those around them) will be.	Thank you for your comment and sharing about your experience. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Himani Sadana (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Atanas Gulubov (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dr Marion Bilich (Individual)	Treatment Recommendations	As a clinical psychologist who has been using EFT in my practice for many years with excellent results when used with people with PTSD, I strongly recommend the inclusion of EFT tapping in your revised guidelines for the treatment of EFT. A review of the research literature confirms my anecdotal impressions, The preponderance of research findings demonstrates that EFT is an evidence-based treatment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		approach for PTSD. I urge you to reconsider this approach. Thank you	
Cathy Reiling (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Elsie Lyons (Individual)	Treatment Recommendations	I support David Feinsteins' submission in the support of EFT for the treatment of PTSD and was both shocked and surprised that EFT had not been included in the light of the body of research showing the speed of cost effectivness of the treatment. I cannot understand why it has not been included.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Rosalind Bubb (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jane Norton (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should definitely be included! It has been life-changing for me and 2 of my grandchildren as well as many clients in my life coaching practice.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dawn Eidelman (Group: ACEP)	Treatment Recommendations	I support the statements submitted by Dr. Robert Schwarz, Past Executive Director of ACEP and by the pantheon of thought leaders in EFT and other Energy Psychology modalities whose purpose is to accelerate trauma healing. ACEP's response and those of other psychologists, psychiatrists, and various licensed mental health practitioners	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		have provided compelling arguments and well-documented efficacy studies for the inclusion of EFT as a psychological trauma treatment protocol by the APA.	
Dawn Moore (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Janet Foster (Individual)	Treatment Recommendations	I support the statement of use of EFT in the clinical guidelines for treating PTSD submitted by ACEP. I have personally used EFT successfully and EMDR in the treatment of PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Fernando de la Cuadra (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lori Mahala (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Noel Forrest (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Valerie Rice (Individual)	Treatment Recommendations	I support the use of Mindfulness-Based Stress Reduction for PTSD, based on published research articles. I taught MBSR to over 150 active duty and Veteran Soldiers. I published research on the results and without a doubt, for those in the	Thank you for your response. We appreciate your experience in helping Veterans and with EFT and other Energy Psychology practices. Lack of inclusion as a recommended treatment

Commenter (Group or Individual?)	Section	Comment	Panel Response
		study, PTSD symptoms were significantly reduced to the point of not being considered active, problematic PTSD. I support the use of Emotional Freedom Technique (EFT) for the same reason. Research has shown it to be effective. I used it with Soldiers and veterans and found it extremely effective in altering perspective, emotional acceptance, and inducing positive coping methods, when other interventions (psychiatrist, medication, psychologists, and group work led by psychologists did not work for the individuals). I support the use of Energy Psychology for the treatment of PTSD (EFT and Energy Psychology use all the same techniques). I support the use of Eden Energy Medicine, as I have used this technique with those with PTSD and found positive results. Eden Energy Medicine training takes two years for entry level and three years to achieve Clinical Practitioner and four years to become an Advanced Practitioner. While other forms of Energy Practices (acupuncture, acupressure, mindfulness meditation, Emotional Freedom Technique (EFT), Eden Energy Medicine (EEM), and nutrition) may be helpful. It is important to vet the practices. Complimentary health care in terms of energy medicine work. If you feel it is beyond the study of a basic MS or PhD in psychology, then I understand that it is not part of professional psychologists purview. However, should a professional psychologist study and obtain certification in a	does not imply that a treatment is ineffective or not helpful. Simply, the evidence base to date, as defined by this process, failed to reach a threshold where it could be recommended. Please see response to comments above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		complimentary technique, then I think it should be able to be used.	
Catherine Floyd (Individual)	Treatment Recommendations	Having worked to help those with PTSD for many years I believe it is important and of great value to include the use of EFT and other kinds of Energy work in the Clinical Guidelines for treating PTSD. And therefore support the Guidelines submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cindy Habig (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Julie Jones (Individual)	Treatment Recommendations	I support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Wendy Klason (Individual)	Treatment Recommendations	It is crucial that methods, such as Emotional Freedom Techniques (Tapping), are included as treatment options. Numerous studies into the effectiveness of EFT in treating PTSD have indicated significant effectiveness. I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Heidi Books (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sar T (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Kelly Claypool (Individual)	Treatment Recommendations	I support ACEP's comments and agree with Dr. Robert Schwartz.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lisa Boyette (Individual)	Treatment Recommendations	I support Dr. Robert Schwarz on behalf of the Group: ACEP - the Association for Comprehensive Energy Psychology and Professor Peta Stapleton statements and recommendations regarding EFTs effectiveness in treating PTSD and trauma.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sandra Christianson (Individual)	Treatment Recommendations	I am a licensed therapist and am certified in EFT Emotional Freedom Techniques and treat a variety of mental health issues including PTSD and trauma. Not only is the body of evidence through the research and meta analysis of the treatment of PTSD demonstrating effectiveness but I have first hand experience with it helping clients. I fully support all comments made by Peta Stapleton, someone who has been developing so many programs using EFT and researching the efficacy of its use with many issues. I also agree with ACEP The Association for Comprehensive Energy Psychology groupâ€™s comments. It would be a disservice to this countryâ€™s mental health crisis to not look into all possible modalities that can benefit the recovery from mental health issues, especially PTSD whether clinical level DSM criteria or subclinical symptoms which a lot of people have. Please include the EFT published research and meta analyses and review its effectiveness as it deserves to be added as a modality and seen as comparable if not more effective than	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		other approved modalities that may not even have as much research to show effectiveness. This country is facing even more problems and trauma and more mental health issues will develop or get worse, please add EFT to the list of ways that people can get the help they need. Thank you	
Teresa "Tee" Edloe (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. As someone who was diagnosed and suffered with severe PTSD; EFT helped me in ways that EMDR alone could not. EFT should definitely be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kara Granger (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Karina Gerhardt-Strachan (Individual)	Treatment Recommendations	I support the comments submitted by Dr. Peta Stapleton, Dr. Dawson Church and the Association for Comprehensive Energy Psychology (ACEP). The science and research behind EFT Tapping continues to expand, with more & more scientific papers being published every year. Over 50 studies are randomized controlled trials (the gold standards in research) and show the efficacy of EFT. The majority of the academic research has been done using Clinical EFT. It is the evidence-based method that has set such a high standard that it is accredited for continuing education credits for doctors, nurses and psychologists (through the Postgraduate Institute for Medicine and partnerships with the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Council for Pharmacy Education (ACPE), the American Nurses Credentialing Center (ANCC) and American Psychological Association (APA) Office of Continuing Education in Psychology (CEP)).	
Jane DeBrown, Psy.D. (Individual)	Treatment Recommendations	After several workshops and trainings on working with PTSD clients using various modalities, I found that I was frequently referring them to colleagues for EMDR. I decided to obtain that certification myself when I heard about EFT and learned that clients could be taught to practice EFT themselves when needed without seeing a therapist. I completed an extensive training program (18-24 months) and became certified to use EFT as a tool. It has been a significant addition to my toolbox, especially for adults with PTSD. I support the comments posted by ACEP, Stapleton, and Church. I use EFT in my practice and have had significant results. Although often described as a combination of exposure therapy and CBT, the somatic aspects of EFT are quite remarkable.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Beata Webb (Individual)	Treatment Recommendations	I have very positive personal experience with EFT for trauma treatment and have extensive knowledge and practice in EFT. I support Professor Peta Stapleton's comment and ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tami Peckham (Individual)	Treatment Recommendations	I support professor Peta Stapleton's comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Angela Morse (Individual)	Treatment Recommendations	EFT Tapping works with those who suffer with PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nicole Chegwyn (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of group ACEP. I also support Dr Peta Stapleton's comment. And thirdly would like to comment on my own personal experience addressing some work acquired PTSD with clinical EFT. My work covered 10 sessions with a clinical EFT practitioner and my health/burnout improved dramatically as my PTSD was processed using EFT over these 10 sessions. Outstanding result and no longer have PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Julie Lohse (Group: ACEP)	Treatment Recommendations	As a member of ACEP for almost 20 years, I have often read the research and observed the positive effects of EFT on an ongoing basis. I fully support the comments posted by ACEP, Stapleton and Church.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dennitza Ilieva (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lionel Walters (Individual)	Treatment Recommendations	I support comments by Dr Peta Stapleton and Dr Robert Schwartz. EMDR had a similar tenuous start in the field but is now widely recognised as an effective treatment for PTSD. Trauma isn't going away anytime soon, and we need as many effective, evidence-based options to offer clients as possible. Emotional Freedom Techniques has evolved beyond its origins in "energy psychology" and is a psychophysiological intervention with a solid evidence base, and its approach and	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		working mechanisms are not dissimilar to those of EMDR. Please give this therapy the attention and validation it deserves.	
Laura Rutlidge (Individual)	Treatment Recommendations	I support the research completed by Peta Stapleton and David Feinsten on Clinical EFT as a cost effective and positive results for the healing of PTSD/CPTSD. I am completing my doctoral research on EFT for Complex Trauma. Why does the APA refuse to consider the raft of positive and critical new research in this area?	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Steve Fearnley (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Toni Mills (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group ACEP - The Association for Comprehensive Energy Psychology. EFT should be included. I have worked successfully using EFT on clients with PTSD.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alicia Grey (Individual)	Treatment Recommendations	I support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Andrea Bassanini (Individual)	Treatment Recommendations	As a Clinical Psychologist, Psychotherapist and Researcher, I support Professor Peta Stapleton, Dawson Church and ACEP comments.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sue Suchocki (Individual)	Treatment Recommendations	I support ACEP's comment. I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
			for Comprehensive Energy Psychology and Professor Stapleton above.
Staci Clark (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP. EFT has really helped me when I am feeling stress or really frustrated about something. It helps my nervous system relax and calm down.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Barbara Saph (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment on this topic. In an age where we have many leading psychological experts sharing research and clinical experience of trauma being stored in the body, somatic/body based techniques such as EFT are not only fast and effective, but could significantly enhance the effectiveness of other clinical practices.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Belinda Pisana (Individual)	Treatment Recommendations	I have concerns about the exclusion of Emotional Freedom Techniques (EFT) from the APA guidelines for first-line PTSD treatments, given the growing body of evidence supporting its efficacy. Meta-analyses indicate that EFT produces comparable outcomes to other evidence-based therapies, including CBT and EMDR, for PTSD treatment. Given this the exclusion seems inconsistent with the APA's commitment to evidence-based practice. While PE, EMDR, and CPT certainly have strong evidence supporting their use, the omission of EFT from the guidelines may limit treatment options for PTSD sufferers who could benefit from this low risk, cost effective approach. I would urge the APA to reconsider the inclusion of EFT in future guideline updates, based on the substantial and growing evidence supporting its efficacy in PTSD treatment. Expanding the range of recommended evidence based first-line treatments could improve outcomes and provide more	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		options for clinicians and patients seeking treatment for PTSD (Dawson et al, 2018 https://doi.org/10.3390/healthcare6040146)	
Betsy Muller (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carol Robertson (Individual)	Treatment Recommendations	It is time to include Psychosensory Processes. Havening is neuroscience-informed, and EFT has many substantial studies. Energy psychology needs to be included, and the information flowing in from neuroscience and the results people experience evidence this.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Christine Bennett (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology". I support Professor Peta Stapleton's comment too. I have been recovering from Complex PTSD for over 20 years. Emotional Freedom Technique aka Tapping has radically changed my healing direction in a positive way. It is a powerful tool that can be learned and self administered. In the 6 years since I have been tapping my healing has been changed incredibly.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Craig Weiner (Individual)	Treatment Recommendations	I serve as the current Chair of the Board of Trustees for the charity International. I have personally been involved with the training of hundreds of licensed mental health care providers. I wish to offer support to the comments submitted by Professor Peta Stapleton, for the comments made by Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and the submitted comments of Dr Shoshana Garfield and Psian. There are now	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		over 300 papers and studies in refereed journals including APA journals. While the quality and size of these studies vary, they have continued to improve over the last 10+ years and positive results of efficacy continue. There are now over 75 RCTs with 95+% reporting significant results, often with dramatic effect size. The greatest number of these studies relate to EFT's efficacy when applied to subjects diagnosed with PTSD. There are most peer reviewed published studies than other approaches you have included in your intended use of guidelins. To not evaluate EFT for inclusion in your guidelines is simply unethical.	
Catherine Rutherford (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment" or any other comments that have been posted on the topic.. EFT is an amazing treatment for PTSD. I use this to help clients through miscarriage and fertility issues and it has a very positive affect mentally, emotionally and physically.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
David Feinstein (Individual)	Treatment Recommendations	I am a licensed psychologist who has been using EFT for more than a decade. It is one of the most effective clinical innovation I've seen in my 50 years of practice.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Dawson Church (Individual)	Treatment Recommendations	The proposed treatment guidelines completely ignore one of the most-studied psychotherapeutic approaches, EFT or Emotional Freedom Techniques. There are many randomized controlled trials comparing EFT to usual care or other evidence-based therapies for PTSD, and they demonstrate equivalence or superiority. There are over 200 studies of EFT, and many meta-analyses, including several of EFT for PTSD. None of this substantial body of scientific literature has been	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		considered in the proposed guidelines. The impact of ignoring EFT is that clinicians, patients and caregivers who otherwise might have had access to a simple, easily-administered, non-pharmacological, and highly effective treatment may not receive its benefits, compromising quality care. Further, the evidence shows that EFT promotes resilience and community wellness while reducing comorbidities such as anxiety, depression, TBI and pain. After EFT treatment, physiological markers such immunity genes, microRNAs, sympathetic arousal, inflammation, blood pressure, heart rate, cortisol, and immunoglobulin levels all show improvement. For the most recent systematic review, see: https://pubmed.ncbi.nlm.nih.gov/36438382/ Clinical guidelines for the treatment of PTSD using EFT are already available, eg https://pubmed.ncbi.nlm.nih.gov/30545069/ and https://pubmed.ncbi.nlm.nih.gov/28678690/ In conclusion, the APA guidelines, if they are to follow their stated methodology, must include EFT.	
Debra Bathgate (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Nicole Francis-Cotton (Individual)	Treatment Recommendations	I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I also support Professor Peta Stapleton's comment. For the past 16 years I have seen tremendous results in my practice utilizing EFT with traumatized patients. My personal results with my clients as well as the research driven evidence of Dr.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Stapleton, Dawson Church and ACEP also prove EFT's efficacy. Therefore EFT should be seriously considered as a treatment protocol for PTSD.	
Emiliya Toneva (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mukti Khanna (Individual)	Treatment Recommendations	During this time of increasing mental health needs, I support APA in adopting an inclusive approach to treatment of PTSD that would include current guidelines as well as evidence based treatments including EFT (Emotional Freedom Technique) that has been proven to help regulate the autonomic nervous system as part of PTSD treatment through memory consolidation in numerous RCT"s evaluating EFT's effectiveness for PTSD. I believe expanding APA treatment modalities in include EFT can help stem the development of complex PTSD in the years to come.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Starla Rose (Individual)	Treatment Recommendations	I fully support the inclusion of EFT and energy psychology in the APA Clinical Practice Guidelines. The growing body of research, including meta-analyses and randomized control trials, provides strong evidence for the efficacy of EFT, particularly in treating PTSD and other emotional health concerns. These approaches are grounded in robust science and have been life-changing for countless individuals, offering accessible and effective healing modalities. I agree with Dr. Robert Schwartz on behalf of Group: ACEP and the Association for Comprehensive Energy Psychology. Furthermore, I support Professor Peta Stapleton's comment,	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		which outlines the importance of recognizing energy psychology and EFT within these guidelines. It is crucial to remain open to innovative, evidence-based treatments that align with the APA's mission of advancing psychological health. I urge you to include EFT in your Clinical Practice Guidelines and ensure this validated approach is recognized and made accessible to those in need. Thank you.	
Gerus Aleksandr (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology, and I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Carolyn Whitehouse (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology".	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Marie McGuinness (Individual)	Treatment Recommendations	I agree with the comments posted by ACEP, Stapleton and Church and have seen significant effectiveness of EFT tapping with my clients. I have also experienced it for myself as I navigated past traumas in my own life	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Cyra Baria (Individual)	Treatment Recommendations	I agree with Professor Peta Stapelton's comment and er research on EFT	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Michelle Hardwick (Individual)	Treatment Recommendations	I support ACEP's comment. I agree with Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sarah Marzillier (Individual)	Treatment Recommendations	I am concerned that the APA has ignored the large evidence base for the Emotional Freedom Technique (EFT) for PTSD. I am unclear why such a large and good body of evidence has been ignored and overlooked. With 3 meta-analyses/systematic reviews and over 9 RCTs showing its efficacy, surely it must be recommended for treatment? In the UK, for example, NICE have recommended it as an area of further review for PTSD (this is before further evidence came out).	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Iréne Ödmark-Hall (Individual)	Treatment Recommendations	I support Dr Peta Stapleton's comments as well as those of Bob Schwartz. As an EFT therapist I often get clients who have done a lot of talk therapy, but Tapping helps in an efficient way, a bit lite EMDR but gentler. Can also be self administred. There is clear and convincing evidence that EFT is an effective and cost effective form of treatment for PTSD in adults. Please consider including this technique in your guidelines.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Jessika Helling (Individual)	Treatment Recommendations	I fully support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Joseph Mitchell (Individual)	Treatment Recommendation	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Judith Daley (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology in addition to supporting Professor Peta Stapleton's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Julie Vandermaat (Individual)	Treatment Recommendations	As a Social Worker of 35 years and a trauma therapist who specialises in helping people recover from sexual abuse trauma, I can say that Clinical EFT is the MOST effective, safest, gentlest and FASTEST modality I have EVER found for helping people with PTSD and complex PTSD. The vast majority of my clients have PREFERRED Clinical EFT, definitely over talk therapy, and many also over EMDR. People like that they can use EFT Tapping themselves when they feel triggered, overwhelmed, anxious. I feel so strongly about the benefits of Clinical EFT for PTSD that I have dedicated theist 8 years of my life to becoming a Certified Master EFT Trainer with EFT International, promoting EFT and training many Psychologists, Social Workers, Therapists and Counsellors in how to do Clinical EFT the slow, safe and gentle way with traumatised clients. I also want to say that EFT is extremely advantageous to us as the people who help people suffering with PTSD. It protects us from vicarious trauma, burnout, and compassion fatigue and restores our hope (where there was very little) that we are able to help people with PTSD. So if you do not respect or care about the clients themselves who suffer daily with EFT, then show some care and respect for the other people you are supposed to be caring for - the Psychologists themselves. In my experience, the vast majority of psychologists who train in EFT, and especially go on to become certified in EFT, prefer it over traditional talk therapy	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		for both their clients and themselves. As they are able to regulate their own nervous system at the same time as they are helping their clients to relate theirs. I support Peta Stapleton's comment I also agree with Dr Robert Schwartz on behalf of ACEP group - that EFT should be included. Please take us seriously and get into the modern world. Somatic therapies are life saving for many clients, and can restore a therapist's enthusiasm and confidence in themselves and their work.	
Susan Kuchenreuther (Individual)	Treatment Recommendations	I support the statement about including EFT in the Clinical Guidelines for treating PTSD submitted by ACEP.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Kora Klapp (Individual)	Treatment Recommendations	The clinical practice would become better adapted to varying circumstances and backgrounds, and such become more efficient. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above. For comments related to contextualizing science, please refer to section 9 of this document.
Leanne Yew (Indiviudal)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Liesbeth Krijtenburg (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz's and Professor Peta Stapleton's comments, and I support the Association of Comprehensive Energy Psychology's submission.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Louise Coyle (Individual)	Treatment Recommendations	I agree with Dr. Robert Schwartz's and Professor Peta Stapleton's comments, and I support the Association of Comprehensive Energy Psychology's submission.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Lynette Delane (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! As someone who has a significant amount of childhood & adult trauma in my life, I tried every therapy available to me including psychotherapy, clinical psychology, cognitive behavioral therapy, art therapy, hypnosis and more. Emotional freedom technique was the first therapy to help me resolve the feelings I had instead of just intellectualisising them.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Miranda Maher (Individual)	Treatment Recommendations	Omission of consideration of EFT and Energy Medicine research into PTSD efficacy	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Mitchell Gainey (Individual)	Treatment Recommendations	Clinical EFT, as demonstrated in Dr. Peta Stapleton's research, is an evidence-based, trauma-informed approach that offers rapid, significant reductions in PTSD symptoms, often within a few sessions. Unlike many traditional methods, EFT combines cognitive and somatic elements, calming the nervous system while allowing clients to safely process trauma. Its gentle, flexible approach makes it accessible to a broader range of individuals, especially those who struggle with exposure-based therapies. With growing international recognition as an effective PTSD treatment, EFT is a powerful, well-researched	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		option that APA should consider to meet the diverse needs of trauma survivors. I support ACEP's comment.	
Mitsuko Ito (Individual)	Treatment Recommendations	I support Dr Robert Schwart's comment on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment as well.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Naomi Janzen (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included! I have worked successfully with clients who had a PTSD diagnosis. After Clinical EFT sessions, they say things like "I have ME back" something they had been told would not be possible. Why would we deny this opportunity to sufferers by not including it? How is that duty of care?	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Natalie Vine (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included!	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Peter Bolton (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Heidi Diamond (Individual)	Treatment Recommendations	"I agree with ""Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology"". I also agree with Dr Peta Stapleton's comments. I finally started to heal after childhood neglect and trauma when using EFT protocols.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		I made no progress in releasing any of the trauma in just 'talk therapy'. I felt heard and had sympathy but my body still carried the trauma in my internal parts. I remained fragmented and continued to use poor coping patterns I learned, including dissociation. I felt insecure in every area of my life and in relationships, especially with family members. My life completely and quickly turned around when I used EFT protocols. I will only go to a psychologist if they know and use EFT from now on. EFT rapidly released the stored trauma from my body helping me to feel lighter, freer, and clearer. I have not returned to the old coping patterns since. Fear, anxiety, distrust, and more have been quickly and safely removed from my body. The memory is still there but those emotions don't overtake my thoughts and body that paralyzed me before. It would be very remiss and illogical for EFT not to be incorporated into and accepted as part of this document/guideline going forward. There is numerous research studies and metanalysis together with the people around the world getting relief through using EFT both for themselves and with trained Practitioners who have not had success with other more traditional modalities. The Veterans are having quicker and sustainable release from their PTSD so why can't every day folks who experienced childhood neglect and trauma not receive the same relief for our PTSD?	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		The proposed updated guidelines miss an important opportunity by failing to highlight emerging, evidence-based therapies that offer enhanced tolerability and access, supported by published, peer-reviewed evidence backed up by meta-analysis on several occasions. The research proof is there and should be acknowledged and included as credible therapy by the APA. It is for the good of mental health for all people everywhere and not to be pushed out. I would happily refer anyone to a professional using EFT. I can only imagine how busy they would be with all the referrals!! Guidelines, such as proposed, should delineate clear pathways for emerging therapies that increase patient and practitioner treatment options and complement the existing recommended approaches. The research proof is there and should be acknowledged and included as credible therapy by the APA for all seeking mental healing. HD"	
Ros Cooper (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included. Please consider the comprehensive research that has been done in this area by Dr Peta Stapleton and others. As an EFT practitioner who has also had a PTSD diagnosis I am fully aware of how effective a treatment for PTSD Clinical EFT is and have seen much evidence of this over my years in practice. It would be detrimental not to support a proven and effective treatment. I encourage this body to do so.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Rossana Mazzaro (Individual)	Treatment Recommendations	Usoprevisto delle linee guida, Raccomandazioni di trattamento, Sostengo il commento dell'ACEP	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Sara Bern (Individual)	Treatment Recommendations	EFT förbundet (The EFT Association) in Sweden support ACEP's comment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Alexander Mitrofanov (Individual)	Treatment Recommendations	I have been working in the fiield of treatment of anxiety disorders since 2009 as a therapist in private practice. I find the APA ignoring energy psychology and EFT appalling and contradictory to pubished research and meta analyses on trauma and PTSD. This indicates bias and goes against the scientific method and values. I agree with "Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology"	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Shoshana Garfield (Individual)	Treatment Recommendations	In 2016, I was commissioned to make a submission on Emotional Freedom Techniques (EFT) PTSD efficacy evidence to the UK government panel doing a PTSD treatment review (NICE – National Institute for Health and Care Excellence). Their first trawl through the literature on PubMed did not yield any EFT documents due at the time to a keyword search issue. After my initial intervention, they agreed to include the EFT papers for consideration, which I organised with an international team of researchers and practitioners. Although most of the papers were eventually excluded on the basis of very harsh criteria, some still made it through, after our team organised a detailed response to their critiques. EFT as a	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		whole was then re-included in the final computations of both efficacy and treatment fiscal practicality. EFT did very well despite the prejudicial attitudes of many Committee members. "NICE, even based on a small selection of papers from all the research available, in its own NMA [Network Meta Analysis] found EFT to be the second most effective and cost-effective therapy for PTSD." https://eftinternational.org/nice-recommendations-for-eft/ The NICE findings include that although EFT was too under-researched at the time and by their strict criteria to be considered for mainstreaming, EFT was so compelling in the quality of the data, persistently large effect sizes and persistence of benefits, that EFT was named as a national priority to research for PTSD treatment, particularly for military-induced Post-traumatic stress disorder. TF-CBT was found to be the most efficacious at the time, but if sessions exceeded eight, EFT was actually found to be more cost effective. High dropout rates and compliance with overall treatment plans are known to be issues with PTSD treatment. This was considered by the NICE Review Committee to be rooted in the difficulty with trust-building in the therapeutic relationship (NICE guideline NG116, Evidence reviews. December 2018. Pages 285-6.) Somatic based therapies, such as Thought Field Therapy (TFT) and Somatic Experiencing (SE), were combined	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		into a new category by the NICE PTSD Committee called Combined Somatic and Cognitive Therapies (CSACTs). There are several advantages the CSACTs, including EFT, have over many other treatments, especially talk-based therapies: 1) RETRAUMATISING MINIMISATION One of the obstacles to accessing and staying in treatment is a perceived or actual threat of needing to talk about, describe, go back to, go back into, and/or re-experience the traumatic incident(s). EFT, TFT and SE do not require the clinician to procure cognitive details of traumatising event(s). EFT and TFT have gentle protocols to address to fear of addressing the traumas before heading in to the traumatising events. The protocols can be administered with details of the body experience of, for instance, fear. Moreover, once the fear of addressing the trauma(s) is done, it is possible with EFT and TFT to continue relieving PTSD and C-PTSD symptoms without a verbal narrative with further protocols. These protocols enable practitioners to minimise abreactions which further supports treatment continuity. 2) TREATING MEMORIES INACESSIBLE DUE TO AGE OF TRAUMA. Averse Childhood Experiences (ACEs) are well known to predispose people with even one ACE to adverse health outcomes and are at a higher risk of PTSD. However, it is impossible to talk about traumatic events that occur before age five or so, the age that cognitive memories often start being retained. However, EFT and TFT have protocols that	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		allow for non-verbal content to be addressed effectively. This is impossible with talking therapies. 3) TREATING MEMORIES INACESSIBLE DUE TO MEMORY LOSS which can arise from, for example, brain injury or dissociative exclusion. Even memories permanently lost to brain damage or are thoroughly inaccessible due to dissociative exclusions can be effectively treated with certain EFT and TFT protocols. This is impossible with talking therapies. 4) GROUP ADMINISTRATION OF EFT/TFT. Whether including details of traumatic events or using protocols that allow for confidentiality, EFT and TFT can be delivered to groups. This has obvious cost-effective implications. Moreover, using the protocols on oneself for one's own issues whilst the group focuses on a single participant allows more leverage of the treatment than mere talking therapies. 5) COMPLEX, DETAILED HW BETWEEN SESSIONS. Once learned, EFT and certain protocols from TFT can be easily self-administered between sessions. The independence, self-reliance, and efficacy of being able to down regulate in the hurly-burly of real life in between therapeutic sessions, has multiple benefits. Firstly, if the patient ends a session feeling raw, they have a tool to assist integration. This has a knock-on effect of associating sessions with progress rather than disruption to life or abreaction, and hence supports compliance with and completion of treatment. Secondly, the patient has reduced dependence on the sessions and on the therapist, and furthermore completes treatment with a tool that supports them for the rest of their lives.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		We in the energy psychology community are aware upon first introduction to EFT and TFT that they can be perceived as, to be blunt and frank, weird looking. Many of us considered it to be weird at first introduction too. It can be absolutely baffling if unfamiliar with dismantling studies and explanatory framework literature to think about why tapping certain areas of the face, torso and hands whilst repeating a few phrases relevant to the incident or issue at hand, either out loud or even silently, could be so effective in bringing about long-term relief of pain and trauma. Therefore, EFT and TFT can initially be quite off-putting. However, dismissing a modality because it looks weird or challenges assumptions isn't part of scientific method. Dismissing a modality on those grounds is merely and unethically being against development in the field. Scientists with integrity follow the academic data. We care enough about people who suffer to explore and find out what works even if protocols take some getting used to, or clinical trials initially have small ns. I am aware that there is an influential minority in the APA throwing their weight around in a stark, unethical denial and wilful ignorance of the literature we have accumulated over the years despite the many structural impediments. EFT unequivocally has a robust efficacy research base in PTSD treatment, more robust than other treatments that your committee has previously approved. There are over 200 published papers in peer-reviewed publications with a multiplicity of PTSD-specific meta-analyses, systemic reviews,	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		as well as dismantling studies. It is therefore absolutely unacceptable, unethical and corrupt to eliminate EFT, due the preponderance of robust efficacy literature, from your review. I further note that all CSACTs deserve inclusion, for instance TFT, SE, and Heart Assisted Therapy (HAT), to name a few. If EFT can't get a word in edgewise even with the effect sizes of EFT's high quality data, then these other, less researched methods have no chance against your blatant, unscientific, unethical prejudice. The chair of this Committee, Dr Lori Zoellner, has a publication on extinction learning: Zoellner, L.A. et al (2017). Enhancing extinction learning in posttraumatic stress disorder with brief daily imaginal exposure and methylene blue: A randomized controlled trial. Journal of Clinical Psychiatry, DOI: 10.4088/JCP.16m10936. Such extinction learning is exactly what is proposed to begin to explain EFT's efficacy in, for instance, this publication by Dr Feinstein: (2023) The Real Reasons Energy Psychology Is Proving to Be Durable: Rejoinder to "Acupressure in Psychotherapy as an Unsinkable Rubber Duck, Reply to Feinstein (2023)" Journal of Psychotherapy Integration 34(2):200-211 DOI:10.1037/int0000328. There is common ground here, room to build bridges between academics. Exclusion of EFT can be easily remedied through simply having the review committee cast a wider net. But not if those so-called academics are committed to the unethical corruption blatantly on display. The NICE PTSD	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		review Committee fought hard in every step of the review process to exclude EFT, but were still willing to look at the papers available at the time, and were willing to engage in clean academic discussion of their objections. The research in EFT has kept getting better and better since 2017, the last date of a paper in the NICE submission. I wholeheartedly agree with the PsiAn comments in entirety. All ACEP and Dr Stapleton's comments are also fully valid. Should the committee insist on only considering meta-analyses and systematic reviews, then the non-inclusion of Emotional Freedom Techniques is an oversight, accidental at best, baldly corrupt at worst. If the Committee could consider the ethical addition of papers beyond the current, narrow scope, I propose all EFT appropriate, PTSD-related documents to be considered as well as smaller studies for all novel approaches. Diepold, J., Schwartz, G. Unpublished. A “Catch-22” For Psychologists and Psychotherapy: Roadblocks to change in the psychotherapeutic community. Trust citation Post-traumatic stress disorder [D] Evidence reviews for psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults. Post-traumatic stress disorder, NICE Guideline NG116, published 5 December 2018	

Commenter (Group or Individual?)	Section	Comment	Panel Response
Dawn Olsen (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. EFT should be included as a safe and clinically effective methodology. With over 200 papers and studies, including in APA journals, on the effectiveness of EFT in the treatment of PTSD, we are doing the public a strong disservice by not including it.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tanya Matthews (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwartz on behalf of group ACEP - The Association for Comprehensive Energy Psychology EFT should be included. I have successfully been treated for PTSD with a certified practitioner. It has changed my life and should be supported so more people may access this life-changing treatment. I can't believe it has taken this long for the APA to endorse it. I have my life back. I can go to work and the mall, I can do all the things everyone else does again. It is not ethical to hold this back from people who need it.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Ana Piccara (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology" and also support Professor Peta Stapleton's comment" too.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Teri Campbell (Individual)	Treatment Recommendations	I support ACEP's comment." or I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology. I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Terri Sheldon (Individual)	Treatment Recommendations	I support ACEP's comment and Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy	Thank you for your comment. Please see the responses to the letter from the Association

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Psychology. Further I support Professor Peta Stapleton's comment too.	for Comprehensive Energy Psychology and Professor Stapleton above.
Jane Whyte (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment. I also agree with Dr Robert Schwartz on behalf of Group: ACEP The Association for Comprehensive Energy Psychology. EFT should be included! It seems completely short-sighted for EFT not be included as a credible and much needed therapy for PTSD. I have worked with many clients who were told that they just had to live with their PTSD and after completing sessions with me they are absolutely delighted to live in a way they never thought possible. It is a travesty for APA to ignore all of the research and evidence about the efficacy of EFT and to not include this in the list of options for treatment.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tina Möller (Individual)	Treatment Recommendations	I agree with Dr Robert Schwarz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology and support Professor Peta Stapleton's comment. EFT is an effective, safe and cost-efficient treatment method. It is also extremely useful as it can be self-administered to reduce stress levels and improve well-being more quickly. Our society needs simple and effective techniques like this.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Tamara Donn (Individual)	Treatment Recommendations	As an EFT trainer for EFT International, I wholeheartedly agree with the comments made by ACEP and Peta Stapleton.	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Chiara Venturi (Individual)	Treatment Recommendations	as a clinical psychologist and psychotherapist I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Commenter (Group or Individual?)	Section	Comment	Panel Response
Wendy Sun (Individual)	Treatment Recommendations	I agree with "Dr Robert Schwartz on behalf of Group: ACEP - The Association for Comprehensive Energy Psychology".	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.
Yolanda Saez Castello (Individual)	Treatment Recommendations	I support Professor Peta Stapleton's comment	Thank you for your comment. Please see the responses to the letter from the Association for Comprehensive Energy Psychology and Professor Stapleton above.

Section 5: Interpersonal Psychotherapy (IPT)

PANEL RESPONSE:

Thank you for your comments. Coventry et al 2020 SR was considered during the Panel's update process, but other reviews that met the Panel's requirements for recency, quality and coverage (i.e., PICOTS and areas of clinical concern) were chosen in its stead. Notably, Karatzias et al. (2019) specifically addressed the impact of treatments on symptoms of complex trauma, an important area of clinical concern for the panel. Hoffman et al. (2018) and Karatzias et al. (2019) both assessed IPT in trauma treatment; evidence from these reviews was insufficient for the Panel to make a definitive recommendation on IPT at this time.

Of note, with regard to IPT's impact on PTSD, Coventry et al. (2020, p. 19) concluded "non-trauma-focused interventions were not generally effective for PTSD symptoms, with only weak evidence in favour of IPT." But regarding symptoms of depression, for which IPT was originally developed, Coventry found "large and significant effects in two trials comparing IPT with controls." (Coventry et al., 2020, p. 19)

The panel applauds the work of clinicians and treatment developers seeking ever better interventions to help trauma survivors. Furthermore, GUP panel members, most of whom are experienced clinicians, agree that psychological treatments, including PTSD treatment, must consider each individual patient's needs and sensibilities, and must consider the complexity of distress wrought by exposure to trauma.

The guideline development process is a vetted, evidence-based process (Institute of Medicine, 2011a); reliable, trustworthy treatment recommendations are based on aggregated data from repeated, well-conducted trials of specific interventions. With regard to the recent review by Markowitz (2024), parameters for GUP's final search for additional reviews to consider were Jan 2023 to Apr 2024, thus this review published May 2024 was not considered. Evidently, the role of IPT in trauma treatment is growing. The value of a scientific, evidence-based approach to guideline development is that as new scientific evidence emerges from well-conducted studies, guideline recommendations will change accordingly. The GUP encourages clinician-scientists and others to continue pursuing and publishing high-quality research on IPT's impact.

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Markowitz, J. C. (2024). Interpersonal psychotherapy for posttraumatic stress disorder: A critical review of the evidence. *The Journal of Clinical Psychiatry, 85*(2), Article 23nr15172. https://doi.org/10.4088/JCP.23nr15172

Commenter (Group or Individual?)	Section	Comment	Panel Response
Mary Burke (Individual)	Treatment Recommendations	Please see the meta-analysis of Coventry et al, 2020: Link. They showed that EMDR, CPT/ TF-CBT and IPT had strong positive treatment effects, while CBT did not. Since then, IPT has been studied in multiple settings, and is the treatment of choice of WHO for refugees. It has been deployed globally for marginalized, traumatized individuals. Its focus on community and family makes it a much better fit for many cultures than the individualistic approaches of CPT. As a clinician, I have found it exceptionally useful for those who have experienced traumatic bereavement, or those who are too overwhelmed by their trauma to start any desensitization. Many people are socially isolated, or with deep shame and fear due to their traumas. IPT allows for gentle desensitization, but always in the context of improving support, communication, and	Thank you for your comment. Please see the response on this topic at the beginning of this section.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		interpersonal closeness. I'm sure you have already been referrred to John Markowitz's 2024 review, DOI:10.4088/JCP.23nr15172	
Barbara Milrod (Individual)	Treatment Recommendations	It is disturbing to me as a psychotherapy researcher and PTSD expert that the members of this guideline committee specifically did not review data from clinical trials. Relying on meta-data that blur together interventions, outcomes and specifically blur quality of psychotherapy outcome studies will perforce yield meaningless results. I am appalled by the evident laziness of this committee's work and submit that I find it irresponsible. It is particularly disturbing that the large body of good clinical trial evidence of efficacy of non-exposure based psychotherapies for PTSD (IPT, in particular, but also PCT) has been ignored. One hopes that these guidelines will either be withdrawn, and a more knowledgeable and academically rigorous committee be found to run a replacement, more responsible set of guidelines, this time guided by primary evidence, or that minimally this committee be disbanded and prohibited from working in this capacity again. This guideline, as it stands, is biased, does not correspond to the evidence that has been accumulated about treatment of PTSD in the last decade, and demonstrates ignorance about quality of clinical trial methodology. For shame.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Please incorporate data from IPT studies, quality of psychotherapy studies, and the large body of data demonstrating limitations of exposure based psychotherapies. Kocsis J, Gerber A, Milrod B Roose SP, Barber JP, Thase ME, Perkins P, Leon AC: A new scale for assessing the quality of randomized clinical trials of psychotherapy. Comprehensive Psychiatry 2010 May-Jun;51(3):319-24 - Markowitz JC, Petkova E, Neria Y, Van Meter PE, Zhao Y, Hembree E, Lovell K, Biyanova T, Marshall RD. Is Exposure Necessary? A Randomized Clinical Trial of Interpersonal Psychotherapy for PTSD. The American journal of psychiatry. 2015;172(5):430-40. Epub 2015/02/14. doi: 10.1176/appi.ajp.2014.14070908. PubMed PMID: 25677355; PMCID: PMC4464805. - Steenkamp MM, Litz BT, Marmar CR. First-line Psychotherapies for Military-Related PTSD. JAMA. 2020;323(7):656-7. doi: 10.1001/jama.2019.20825. - Steenkamp MM, Litz BT, Hoge CW, Marmar CR. Psychotherapy for Military-Related PTSD: A Review of Randomized Clinical Trials. JAMA. 2015;314(5):489-500. doi: 10.1001/jama.2015.8370. -Schnurr PP, Chard KM, Ruzek JI, Chow BK, Resick PA, Foa EB, Marx BP, Friedman MJ, Bovin MJ, Caudle KL, Castillo D, Curry KT, Hollifield M, Huang GD, Chee CL, Astin MC, Dickstein B, Renner K, Clancy CP, Collie C, Maieritsch K, Bailey S, Thompson K, Messina M, Franklin L, Lindley S, Kattar K, Luedtke B, Romesser J, McQuaid J, Sylvers P, Varkovitzky R, Davis L,	existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ Please also see the response on this topic at the beginning of this section. As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		MacVicar D, Shih M-C. Comparison of Prolonged Exposure vs Cognitive Processing Therapy for Treatment of Posttraumatic Stress Disorder Among US Veterans: A Randomized Clinical Trial. JAMA Network Open. 2022;5(1):e2136921-e. doi: 10.1001/jamanetworkopen.2021.36921.	
Christie Schueler (Individual)	Treatment Recommendations (p. 11)	The draft guideline states (page 11) that there is insufficient evidence to recommend for or against the use of Interpersonal Psychotherapy (IPT) for PTSD. There have been numerous studies of IPT for PTSD. Recently, the Journal of Clinical Psychiatry published an article on this topic (Markowitz JC: Interpersonal psychotherapy (IPT) for posttraumatic stress disorder: A critical review of the evidence. J Clin Psychiatry 2024; 85(3):23nr15172), and it demonstrates the peer-reviewed publication of 13 clinical trials, including 7 RCTs from multiple independent research groups in which IPT has held its own with Prolonged Exposure and sertraline while surpassing weaker comparators. IPT also had lower dropout than Prolonged Exposure (n=2 studies) and possible advantages for patients with sexual trauma (n=1). Keefe (Am J Psychotherapy 2024;77:101-3) reported similar benefits for IPT in a recent meta-analysis. The body of evidence surpasses the objective bar for an evidence-based intervention. IPT may not be established as a first-line treatment, but it has adequate evidence to support its use in PTSD as a second-line recommended intervention. Moreover, IPT provides a non-exposure alternative to the options these draft guidelines currently	Thank you for your comment. Please see the response on this topic at the beginning of this section.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		list. Non-exposure alternatives are important to consider, particularly when individuals seeking treatment are not open to or ready for an exposure-based treatment, but still require an effective intervention to alleviate symptoms and improve functioning. I urge the committee to consider including IPT for PTSD in the final Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. Please consider adding IPT for PTSD to the recommended second-line interventions for PTSD	
John Markowitz (Individual)	Treatment Recommendations	The draft guideline states (page 11) that there is insufficient evidence to recommend for or against the use of interpersonal psychotherapy (IPT) for PTSD. Having been briefly involved with the PTSD guideline workgroup, I know that your investigation of primary sources and of recent publications was limited. If the group has not seen my recent Journal of Clinical Psychiatry article on this topic (Markowitz JC: Interpersonal psychotherapy (IPT) for posttraumatic stress disorder: A critical review of the evidence. J Clin Psychiatry 2024; 85(3):23nr15172), it demonstrates the peer-reviewed publication of 13 clinical trials, including 7 RCTs from multiple independent research groups in which IPT has held its own with Prolonged Exposure and sertraline while surpassing weaker comparators. IPT also had lower dropout than Prolonged Exposure (n=2 studies) and possible advantages for patients with sexual trauma (n=1). Keefe (Am J Psychotherapy 2024;77:101-3) reported similar benefits for IPT in a recent meta-	Thank you for your comments. In the course of the guideline update process time allowed the Panel search for additional literature to include more information about treatments of clinical interest not previously or adequately addressed in the initial , nine (9) systematic reviews (i.e., Choi et al 2020; Hoskins et al 2021; Illingworth et al 2021; Jericho et al 2022; Karatzias et al 2019; Roberts et al 2022; Sijercic et al 2022; Williams et al 2022). Of course, deadlines for guideline completion informed the search process: the second wave of updated searches sought systematic reviews published between January 2023 and April 2024. Understandably, your paper, published May 29, 2024, (i.e., “Interpersonal psychotherapy for posttraumatic stress disorder: A critical review of the evidence,” Journal of Clinical Psychiatry) was not available at the time of the additional literature search.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		analysis. That corpus surpasses the objective bar for an evidence based indication. IPT may not be established as a first line treatment, but it surely has adequate evidence to support its use in PTSD. Moreover, IPT provides a non-exposure alternative to the options these draft guidelines currently list.	APA's updated guidelines for PTSD accord with best practices and standards for guideline development (IOM, 2011a). This choice of methodology is based on values expressed in the APA Presidential Task Force on Evidence-Based Practice (2006) and the APA's (2021) Professional Practice Guidelines on Evidence-Based Psychological Practice in Healthcare. Every choice involves a trade-off, an opportunity cost. APA's choice of methodology placed a premium on scientific rigor, transparency of process, including the minimizing of conflicts of interest. In other words, you can't have it all. The choice for APA and the Panel was scientific rigor over name, fame, charisma, group pressure or individual opinion, seeing this choice as the best choice for writing reliable and trustworthy guidelines. And yet, to broaden the scope informing clinical practice guideline recommendations, APA included a range of mental health professionals and a community member on the panel; when considering harms and burdens of interventions, it incorporated a broad range of information. Based on the aggregated findings of large sample sizes and rigorously conducted studies, science is limited. The goal of the update Panel was to see if new science altered or debunked the 2017 CPG recommendations for the treatment of PTSD with

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			adults. Most of the previous recommendations were upheld. A valuable feature of science is that it is tentative: when there is better evidence from well-conducted research, conclusions change. The field of PTSD treatment is dynamic. Clinical practice guidelines are therefore regularly updated to consider new developments in the science, and to reconsider previous recommendations based on new research. Please also see the response on this topic at the beginning of this section.
Christine A. Courtois, Ph.D., ABPP (Individual)	Treatment Recommendations	In a related vein, more attention to the Markowitz et al. research findings about their Interpersonal Psychotherapy for PTSD treatment method as an effective an alternative to exposure is suggested.	Thank you for your comment. Please see the response on this topic at the beginning of this section.

Section 6: Eye-Movement Desensitization and Reprocessing (EMDR)

PANEL RESPONSE:

Thank you for your comments. With regard to the request for clarity regarding the evidence of bilateral stimulation in EMDR treatment, this is outside the purview of the GUP. The GUP's recommendations are based on the integration of data from systematic reviews of the evidence. While the GUP addresses mechanisms of change in PTSD treatment (see section by that title in the guideline document), data on bilateral stimulation was lacking.

With regard to differences between the APA CPGs and those of the ACOEM, the APA's guideline development process follows IOM's (2011 a, b) standards, a vetted and evidence-based guideline development methodology that relies exclusively on systematic reviews. This approach separates the guideline development process from the meta-analytic process to keep bias at a minimum, and all systematic reviews meet the IOM (2011b), AMSTAR (Shea et al. 2017), Agency for Healthcare Research and Quality (2023), or Cochrane (Higgins et al., 2024) quality criteria. Underlying this process of incorporating the highest quality research and systematic reviews of that research, is APA's intention to write clinical practice guidelines that are not only trustworthy and reliable, but that, in the hands of competent clinicians, optimize mental health care (Hamblen et al., 2019) for trauma survivors. The IOM (2011a) standards for guideline development are widely used and referenced in guideline development by many healthcare organizations, professional associations, and more across the United States, for example by the American Psychiatric Association, U.S. Preventive Services Task Force, American College of Physicians, Centers for Disease Control and Prevention, and many more. APA's recommendations differ in some ways from those developed by the ACOEM. However, the APA's CPGs are comparable to those written by other professional organizations (see section in the narrative, "How the APA Compares to Other Treatment Guidelines for the Problem"). Clinical expertise was a part of APA's clinical practice guideline decision-making. Most GUP members are experienced clinicians. Their expertise, along with data from the fifteen (15) systematic reviews and the opinions and experiences of the panel's community member were incorporated into CPG recommendations. The GUP agrees that psychological treatments, including PTSD treatments, must consider each individual patient's needs and sensibilities. The value of a scientific, evidence-based approach to guideline development is that as new scientific evidence emerges from well-conducted studies, guideline recommendations will change accordingly. The GUP encourages clinician-scientists and others to continue pursuing and publishing high-quality research on promising treatments' impact for individuals suffering the negative sequelae of trauma exposure.

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Higgins, J. P. T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2024). *Cochrane handbook for systematic reviews of interventions* (Version 6.5). https://training.cochrane.org/handbook

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Commenter (Group or Individual?)	Section	Comment	Panel Response
Carl Grahn (Individual)	Treatment Recommendations	Please don't include EMDR as an evidence-based treatment for PTSD (the stats. are super questionable and the eye movement does NOTHING!- it is the exposure skills in EMDR that's driving the change).	Thank you for your comment. Please see the response on this topic at the beginning of this section.
Jia Jian Tin (Individual)	Appendix J	please be clearer about the lack of evidence of bilateral stimulation. EMDR practitioner are lying to their patients when stating it is backed by science when the science says bilateral stimulation doesn't work.	Thank you for your comment. Please see the response on this topic at the beginning of this section.
Theodore Witzig (Individual)	Treatment Recommendations	It is disappointing to see that the authors of this document have not given EMDR a higher recommendation. I strongly urge the panel to reconsider and place EMDR at the top tier of recommendation. I am concerned that bias continues to exist against EMDR because of questions regarding its mechanism of action and questions about the role of eye movements. I feel that the DOD/VA guidelines do a better job of reflecting the current research and clinical guidance for psychologists. Line	Thank you for your comment. Please see the response on this topic at the beginning of this section.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		#2058 acknowledges the difference in the APA guidelines, but does not provide an adequate response and rationale.	
Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP)	Treatment Recommendations	The APA makes "conditional for" recommendations (second line) for Cognitive Therapy (CT), Eye Movement Desensitization and Reprocessing (EMDR), and Narrative Exposure Therapy (NET). ACOEM did not address either CT or NET separately, but their recommendation appears reasonable to me based on my review of their evidence. The recommendation for EMDR differs from ACOEM, with respect to the use of eye-movements. • ACOEM recommended the exposure component of EMDR, but recommended against ("Not recommended") for the eye-movement component. By contrast, APA made a "conditional for" recommendation in general for EMDR. • Beginning on line 1722, the APA GL includes a discussion of EMDR, noting the potential controversy and uncertainty about the mechanisms, specifically eye movements. Ultimately, they conclude (line 1735-1737) "EMDR may be an effective psychotherapy for PTSD, though it is unclear the specific mechanism of action or whether eye movements themselves in EMDR are necessary." • The primary evidence regarding EMDR appears to have been a meta-analysis of Lee and Cuijpers (2013), which is noted not to have been specific to PTSD, which showed a preponderance of advantages for eye movements (lines 1723-1732). However, the APA GL also notes that Cuijpers (2020) did not replicate the finding, and found no advantage for EMDR "relative to exposure without	Thank you for your comment. Please see the response on this topic at the beginning of this section.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		eye movements, including five studies on PTSD" (lines 1732-1734). • Of note, ACOEM found moderate evidence against the efficacy of eye movements in Sack (2016) , which the APA GL does not cite. Sack (2016) found no advantage to eye movements compared to external focus on a stationary hand, for example. • Given the failure of Cuijpers (2020) to replicate their earlier findings with respect to eye movements, as cited by the APA GL, and given the evidence from Sack (2016), I would encourage the APA to revise their recommendation regarding EMDR to be in line with the ACOEM GL. Specifically, the exposure component of EMDR has solid research support across multiple applications and studies, whereas the eye movement component has equivocal support at best, and at least moderate evidence against their efficacy. Sack M, Zehl S, Otti A, Lahmann C, Henningsen P, Kruse J, Stingl M. A Comparison of Dual Attention, Eye Movements, and Exposure Only during Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder: Results from a Randomized Clinical Trial. Psychother Psychosom. 2016;85(6):357-365. doi: 10.1159/000447671. Epub 2016 Oct 15. PMID: 27744424.	
Derek Farrell (Group: Journal of EMDR Practice	Treatment Recommendations	This summary statement responds to the American Psychological Association's (APA) latest guidance for the treatment of posttraumatic stress disorder (PTSD). The Editors of the Journal of EMDR Practice and Research and a panel of trauma experts	Thank you for your review and feedback on the draft guideline. Please refer to the beginning of this section for the Panel's overall response to this topic.

Commenter (Group or Individual?)	Section	Comment	Panel Response
& Research and EMDR Scholars Forum)		with skills in academia, clinical practice, and research/knowledge exchange instigated the authorship of this statement. Furthermore, for additional context, this panel represents multi-theoretical expertise in empirically supported trauma interventions, including Eye Movement Desensitisation and Reprocessing (EMDR) therapy. As academics and researchers, we are committed to evidence-based research, practice-based research, and real-world research on performing clinical and social research in applied settings. In further context, many authors of this summary belong to the EMDR therapy and Trauma-Focused Cognitive Behavioral Therapy communities. A summary of the latest APA guidelines for the treatment of PTSD in adults is as follows: 1st Line Treatments for PTSD in Adults: 1. Cognitive Processing Therapy (CPT) 2. Prolonged Exposure (PE) 3. Trauma-Focused Cognitive Behavioral Therapy (CBT) 2nd Line Treatment for PTSD in Adults: 4. Cognitive Therapy (CT) 5. Eye Movement Desensitization and Reprocessing (EMDR) 6. Narrative Exposure Therapy (NET) In countenance, we do not support the assertion of EMDR therapy as a '2nd line treatment' for PTSD in adults. That said, we do support the importance of the need for 'individualized	The Panel did consider including the Yunitri et al (2023) meta-analysis though it ultimately decided to not include it due to multiple factors, including feedback we received during the 2023 PICOTS/identified systematic reviews public comment period. The Panel was limited to the studies that were in the identified systematic reviews / meta-analyses and did not examine whether to include/exclude individual RCTs in order to keep bias at a minimum. We understand that cost-effectiveness is important, however it falls outside the scope of the panel's work. When the clinical practice guideline initiative was formed in 2010, the Advisory Steering Committee decided that the guideline recommendations would be based on the best available science, not the cost.

Commenter (Group or Individual?)	Section	Comment	Panel Response
		treatment' and that patients should be active agents in shared decision-making to determine the most appropriate treatment plan. We acknowledge the significant undertaking in completing such a critical clinical treatment guideline. While respectful of due diligence, it is our collective viewpoint that the American Psychological Association's (APA) latest guidelines on posttraumatic stress disorder (PTSD) treatment exhibit significant inconsistencies when compared to other international treatment guidelines, specifically concerning Eye Movement Desensitization and Reprocessing (EMDR) therapy. These inconsistencies are primarily rooted in APA's methodology and undermine the validity and relevance of the evidence base on which the guidelines are founded. Our response, therefore, is as follows: **Summary Document: Critical Evaluation of the APA PTSD Treatment Guidelines and Methodology** **Introduction** The current APA guidelines for PTSD treatment face critical scrutiny, particularly of their reliance on outdated and methodologically weak evidence. The summary of psychological evidence relies on published systematic reviews that are either outdated or have been assessed to have low quality. For example, the guidelines rely in part on the 2022 Jericho et al. meta-analysis for evaluating Eye Movement Desensitization and Reprocessing (EMDR) therapy, which is based on studies up to 2019 and lacks long-term follow-up or remission comparisons.	

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		On page 92 of the guidelines, it is acknowledged that this paper was assessed to be of low quality. The only review described as high quality involving psychological treatment was by Hoffman et al. (2018). The guidelines stated that reviews that were 5 years old by 2024 would be excluded. So, the inclusion of this review contravenes the guidelines' intended methodological approach. In contrast, a more recent and methodologically robust meta-analysis by Yunitri et al. (2023), which includes studies up to March 2021 and evaluates longer-term outcomes, presents more robust evidence for EMDR's efficacy but was not considered for the APA guidelines for PTSD treatment. **Strengths of the Yunitri et al. (2023) Meta-Analysis** The Yunitri et al. meta-analysis encompasses 98 studies involving over 5000 patients, including those with complex PTSD, and offers a comprehensive comparison of EMDR with Cognitive Processing Therapy (CPT). Both therapies showed moderate-to-large effects on long-term outcomes, with moderate heterogeneity. Notably, the study found no significant risk of bias in EMDR trials. Additionally, it includes a 6-month follow-up, which was absent in earlier studies, offering a more thorough evaluation of the sustained effects of treatments. Despite its strengths, it overlooks three recent controlled outcome studies (Boterhoven de Haan et al., 2020; Matthijssen et al., 2023; Van Vliet et al., 2021), which may provide further valuable insights, including that treatment effects of EMDR are stable at 12 months follow-up.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		7. Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., van Es, S. M., Menninga, S., Meewisse, M.-L., … Arntz, A. (2020). Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: randomised clinical trial. *The British Journal of Psychiatry*, *217*(5), 609–615. https://doi:10.1192/bjp.2020.158 8. Matthijssen, S. J. M. A., Brouwers, T. C. & De Jongh, A. (2024). Visual Schema Displacement Therapy versus Eye Movement Desensitization and Reprocessing therapy versus waitlist in the treatment of posttraumatic stress disorder: Results of a randomized clinical trial. *Frontiers in Psychiatry, 15*:1377108. http://doi.org/10.3389/fpsyt.2024.1377108 9. Van Vliet, N. I., Huntjens, R. J. C., Van Dijk, M. K., Bachrach, N., Meewisse, M.-L., & De Jongh, A. (2021). Phase-based treatment versus immediate trauma-focused therapy for post-traumatic stress disorder due to childhood abuse: a randomized clinical trial. *BJPsych Open, 7*(6), e211. https://doi:10.1192/bjo.2021.1057 **Need for an Updated Guideline** The call for an updated guideline stems from the evolving nature of PTSD treatment, particularly in addressing specific populations such as refugees, military personnel, and individuals with comorbid conditions. The last few years have also seen significant methodological innovations, including active controls, head-to-head comparisons, network meta-analysis, and cost-	

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		effectiveness studies. These developments should be considered in the updated guideline to provide a comprehensive and current understanding of the comparative benefits of PTSD treatments. **Evaluating the Jericho et al. (2022) Meta-Analysis** While Jericho et al.'s network meta-analysis (NMA) plays a crucial role in directly comparing trauma-focused treatments, there are better choices of reviews. Even if Yunitri et al. (2023) were not included, other high-quality, more recent meta-analyses were available. In terms of breadth of scope, Jericho et al. (2022) included fewer trials (82) than other more high-quality systematic reviews, such as Mavranezouli et al. (2020), which analyzed 90 trials. Other areas of improvement include using systematic reviews that include long-term follow-up and remission comparisons; otherwise, the guidelines are constrained from commenting on the long-term stability of the treatment effects. Finally, Jericho et al. (2022) collapsed different types of trauma-focused CBT into one category, blurring the likely different outcomes between these approaches, as was purported in the guidelines published by the USA Department of Veterans Affairs/ Department of Defence (2023). **Concerns with Other Systematic Reviews** Several other systematic reviews have been proposed to complement or replace Jericho et al. (2022), but some present concerns regarding their methodological rigor or applicability. For instance, the Choi et al. (2021a &b) review, which aims to	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		address complex PTSD, uses a definition of "complex trauma" that may not align with the ICD-11 criteria for complex PTSD. In contrast, Karatzias et al. (2019), which applies the ICD-11 criteria more strictly, has been cited significantly more (213 times vs. 4) and provides a broader scope with 51 RCTs compared to Choi's 42, making it a stronger candidate for inclusion. **Cost-Effectiveness Considerations** While the current guidelines focus primarily on clinical efficacy, there is emerging evidence regarding the cost-effectiveness of different PTSD treatments. Including cost-effectiveness in the guideline, update would be valuable for healthcare providers making treatment decisions based on budget constraints. The systematic review by Mavranezouli et al. (2020) on cost-effectiveness could provide useful insights. **Issues with Guideline Methodology** The APA guidelines rely heavily on systematic reviews and meta-analyses. Including studies over five years old renders the APA's approach outdated by the time of publication, especially when compared to other international guidelines. This gap is particularly problematic in the rapidly evolving field of PTSD treatment, where new studies frequently emerge, making older evidence less reflective of contemporary treatment effectiveness. The process by which the current guidelines were developed has several issues. The decision to limit the number of systematic reviews considered and the reliance on a small group of "high-	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		quality" reviews resulted in a narrow and potentially skewed evidence base. Of the 15 reviews included, only two (Hoffman et al., 2018; Williams et al., 2022) were considered high quality, and their conclusions were heavily weighted in favor of pharmacological treatments, particularly in the case of EMDR, which was unduly influenced by a single study. Moreover, based on expressions of interest, the panel's composition and review selection process may have led to biases in choosing studies that align with preexisting preferences rather than a rigorous evaluation of all available evidence. It is noted that the panel did not include any individual with robust, in-depth knowledge and clinical expertise in EMDR Therapy. High-quality studies that could have strengthened the evidence base, such as Lewis et al. (2020) and Mavranezouli et al. (2020), were excluded. The Mavranezouli et al. (2020) paper highlights EMDR therapy as 'more cost-effective than TF-CBT' despite TF-CBT having the most extensive evidence base. This limitation undermines the guideline's robustness and potential impact on clinical practice. **Disputable Evidence and Inconsistent Comparisons:** The evidence base in the APA guidelines, particularly for EMDR therapy, is drawn from systematically flawed reviews and meta-analyses. For example, Jericho et al. (2022) include studies only up to 2019, with some already covered in the Hoffman et al. (2018) review, resulting in redundant and outdated evidence. Had the committee chosen a recent meta-analysis such as Yunitri	

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		et al. (2023), then its conclusion would at least be based on literature published up to 2021. Practitioners reading guidelines published in 2024 or 2025 would assume they include RCTs. This is not the case with the guidelines in their current form. Additionally, the meta-analysis methods, such as not considering long-term follow-up or remission rates, undermine the conclusions drawn about EMDR's efficacy. So, even when the APA guidance is eventually published, it will ostensibly already be obsolete and will fail to provide the most up-to-date clinical guidance in the treatment of PTSD in adults. This stands in stark contrast to international guidelines that have more frequently updated their recommendations to align with the latest evidence, particularly concerning EMDR's effectiveness across various patient populations and complex PTSD cases. **Conclusion and Recommendations** Given the rapid advancements in PTSD treatment research and the methodological shortcomings of the current guidelines, it is crucial to update the guidelines to reflect the most recent, rigorous, and comprehensive evidence available. Key recommendations include: 10. Replacing or supplementing the Jericho et al. (2022) meta-analysis with Yunitri et al. (2023), incorporating recent studies and long-term follow-up data. This would offer greater precision regarding the robustness of EMDR therapy as a first-line treatment for PTSD.	

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		11. Incorporating additional systematic reviews, particularly those that strictly adhere to ICD-11 criteria for complex PTSD, such as Karatzias et al. (2019), would ensure a more robust narrative in support of EMDR therapy as a first-line treatment intervention for PTSD. 12. Including a review of cost-effectiveness studies to provide a broader perspective on the relative value of different treatments. 13. Addressing the methodological limitations of the guideline development process by ensuring a more comprehensive and transparent review of all high-quality studies. The guidelines' "grid" spreadsheet (referenced in the document) contains data from several studies but reveals inconsistencies in how the evidence was presented: a. **EMDR Comparison**: EMDR's effectiveness is compared to other treatments like PE (Prolonged Exposure) and CPT (Cognitive Processing Therapy). EMDR was shown to have moderate benefits but with variable outcomes across different studies. For example, EMDR was found to be less effective than PE and CPT in some measures (such as symptom reduction and loss of diagnosis) but still suggested as a second-line treatment for PTSD.	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		b. **Outcome Measures**: The "grid" reveals the outcomes of EMDR as measured against waitlist (WL), treatment as usual (TAU), and no treatment (NC), showing moderate benefits. However, the authors note that the comparisons lack clarity on important outcomes, such as long-term efficacy (e.g., 1-year post-intervention). 5. Final Recommendation on EMDR • **Moderate Benefits**: EMDR shows moderate benefits compared to other treatments for PTSD but with limitations in addressing complex PTSD and long-term outcomes. • **Unclear Evidence**: While EMDR is suggested over no treatment or waitlist, the evidence for its superiority over other treatments is unclear, especially concerning complex presentations and sustained outcomes. Overall, the EMDR Scholars Forum believes that this document critiques the limited scope and outdated nature of the evidence used in the current APA PTSD guidelines and stresses the importance of incorporating more recent, comprehensive, and high-quality evidence. That said, the five issues highlighted by adopting these recommendations, the updated guidelines could provide a more accurate and comprehensive roadmap for PTSD treatment, demonstrating the empirical robustness of EMDR Therapy in	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		ensuring that the most effective therapies are available to those in need. In conclusion, the APA's current guidelines on PTSD treatment, particularly in their endorsement of EMDR therapy, are methodologically flawed, lack transparency, rely on disputable and outdated evidence, and fail to incorporate the most recent advancements in PTSD research. As a result, these guidelines stand in stark contrast to international standards, which consistently provide more up-to-date, comprehensive, and rigorous recommendations for PTSD treatment. The outdated nature of the evidence included in the APA guidelines risks compromising their recommendations' clinical applicability and effectiveness. As EMDR Therapy is now in its fourth decade, despite persistent criticisms and undermining, the transformative impact of this therapy in alleviating PTSD in adults continues unabated. As clinicians, EMDR Therapy's transformative nature will continue as a robust, contemporary, empirically supported therapy. In summary, we would be grateful if you could acknowledge receipt of this Summary Statement highlighting inconsistencies in the APA's latest PTSD Guidelines regarding EMDR Therapy. We look forward to your response. ***References:*** Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., Van Es, S. M., Menninga, S., Meewisse, M. L., ... & Arntz, A. (2020). Imagery rescripting and eye movement desensitisation and reprocessing	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		as treatment for adults with post-traumatic stress disorder from childhood trauma: randomised clinical trial. *The British Journal of Psychiatry*, *217*(5), 609-615. https://doi:10.1192/bjp.2020.158 Choi, H., Lee, W., & Hyland, P. (2021a). Factor structure and symptom classes of ICD-11 complex posttraumatic stress disorder in a South Korean general population sample with adverse childhood experiences. *Child Abuse & Neglect*, *114*, 104982. https://doi.org/10.1016/j.chiabu.2021.104982 Choi, H., Kim, N., & Lee, A. (2021b). ICD-11 posttraumatic stress disorder (PTSD) and complex PTSD among organized violence survivors in modern South Korean history of political oppression. *Anxiety, Stress, & Coping*, *34*(2), 203-214. https://doi.org/10.1080/10615806.2020.1839889 Hoffman, V., Middleton, J. C., Feltner, C., Gaynes, B. N., Weber, R. P., Bann, C., Viswanathan, M., Lohr, K. N., Baker, C., & Green, J. (2018). Psychological and pharmacological treatments for adults with posttraumatic stress disorder: a systematic review update (AHRQ Publication No. 18-EHC011-EF). U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. https://doi.org/10.23970/AHRQEPCCER207 Jericho, B., Luo, A., & Berle, D. (2022). Trauma-focused psychotherapies for posttraumatic stress disorder (PTSD): a systematic review and network meta-analysis. Acta Psychiatrica Scandinavica, 145(2), 132–155. https://doi.org/10.1111/acps.13366	

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		Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., Hyland, P., Maercker, A., Ben-Exra, M., Coventry, P., Mason-Roberts, S., Bradley, A., & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. Psychological Medicine, 49(11), 1761-1775. https://doi.org/10.1017/S0033291719000436 Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., ... & Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: A network meta-analysis. *Psychological medicine*, *50*(4), 542–555. https://doi:10.1017/S0033291720000070 Matthijssen, S. J. M. A., Brouwers, T. C. & De Jongh, A. (2024). Visual Schema Displacement Therapy versus Eye Movement Desensitization and Reprocessing therapy versus waitlist in the treatment of posttraumatic stress disorder: Results of a randomized clinical trial. Frontiers in Psychiatry, 15:1377108. http://doi.org/10.3389/fpsyt.2024.1377108 U.S. Department of Veterans Affairs/Department of Defense. (2023). *VA/DoD clinical practice guidelines: Management of posttraumatic stress disorder and acute stress disorder 2023*. https://www.healthquality.va.gov/guidelines/MH/ptsd/ Van Vliet, N. I., Huntjens, R. J. C., Van Dijk, M. K., Bachrach, N., Meewisse, M.-L., & De Jongh, A. (2021). Phase-based treatment versus immediate trauma-focused therapy for post-traumatic	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		stress disorder due to childhood abuse: a randomized clinical trial. BJPsych Open, 7(6), e211. http://doi:10.1192/bjo.2021.1057 Williams, T., Phillips, N. J., Stein, D. J., & Ipser, J. C. (2022). Pharmacotherapy for post-traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD002795.pub3 Yunitri, N., Chu, H., Kang, X. L., Wiratama, B. S., Lee, T. Y., Chang, L. F., ... & Chou, K. R. (2023). Comparative effectiveness of psychotherapies in adults with posttraumatic stress disorder: a network meta-analysis of randomised controlled trials. *Psychological medicine*, *53*(13), 6376-6388. https://doi:10.1017/S0033291722003737 Our fundamental concern is that the APA revised guidelines will be obsolete on publication. The methodological decisions the APA guideline committee has made mean that the primary studies relied upon will all be over five years old when the APA guidelines are eventually published. In particular, the most recent psychological intervention studies included in Hoffman (2018) are from 2017, Jericho (2022) from 2019, Choi (2021 a&b) from 2015, and Karatzias (2019) from 2015. This starkly contrasts other recent guidelines, such as the UK NICE Guidelines for PTSD, which were published in 2018 and	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		included data from primary studies up to 2017 (Mavranezouli, 2020). There were also missed opportunities to correct this deficiency, namely deciding not to include data from more recent studies held within the PTSD repository and not including more recent high-quality systematic reviews of psychological interventions for PTSD. Because of the weaknesses of this approach, our concern is that the reviews the APA guideline committee has relied upon exclude important recent research on EMDR. Hence, the APA committee has made their recommendation for EMDR based on outdated information.	
Sue Hobbs (Group: CYF)	Treatment Recommendations	Lines 527-528, 735-742; 2217-2218: EMDR is mentioned 25 times in this document. What does the research say? Does eye movement itself treat PTSD, or is it the cognitive processing of trauma? If the research does not support the eye movement component of EMDR, we recommend curtailing the mentioning of this therapy. Please make certain your recommendations are backed by science.	Thank you for your comment. Please see the response on this topic at the beginning of this section.

Section 7: Written Exposure Therapy (WET)

Commenter (Group or Individual?)	Section	Comment	Panel Response
Paula Schnurr (Individual)	Treatment Recommendations	I agree with the decision to review therapies individually. In the VA/DoD guideline, we did not make a specific recommendation for the class of trauma-focused CBTs, however, because they were diverse and often a protocol was tested in only one study. Regarding the specific recommendations, it is not clear why evidence for WET is insufficient given the evidence and given the non-inferiority of WET vs. active interventions, for which your review found the SOE to be moderate. If there is moderate evidence that WET is not inferior to recommended first-line treatments, how is the evidence for WET insufficient. Is the fact that most studies are comparative effectiveness studies rather than studies with a control group? This should not result in a split and confusing recommendation. I worry about this setting a precedent as there are more and more comparative effectiveness trials.	Thank you for your comments. At this time the APA guideline development process follows the IOM's (2011 a, b) standards. This vetted and evidence-based guideline development methodology relies on systematic reviews. As well, it separates the guideline development process from the meta-analytic process to keep bias at a minimum. Furthermore, systematic reviews must also meet AMSTAR (Shea et al., 2017) or the Agency for Healthcare Research and Quality (2023), or Cochrane (Higgins et al., 2024) quality criteria. Underlying this process incorporating the highest quality research and systematic reviews of that research, is APA's intention to write clinical practice guidelines that are not only trustworthy and reliable, but that, in the hands of competent clinicians, optimizes mental health care (Hamblen et al., 2019) for trauma survivors. Of note is the fact that this approach is consistent across professional and other mental health stakeholder organizations writing CPGs for PTSD (see section in the narrative, "How the APA Compares to Other Treatment Guidelines for the Problem").

Commenter (Group or Individual?)	Section	Comment	Panel Response
Denise Sloan (Individual)	Treatment Recommendations	The committees decision to not include WET as a recommended treatment because more studies are needed in which waitlist or TAU conditions are included is frustrating. This is because it is no longer possible to get funding to conduct treatment studies using waitlist comparison condition and the studies conducted with WET have used a more rigorous treatment comparison- CPT and PE. Funding agencies also do not like TAU conditions because it could mean anything and could vary considerably across participants. In addition, superiority testing was conducted in one of the non-inferiority studies and reported in a response to the 2018 JAMA Psychiatry publication with no differences observed between the two treatment conditions (WET vs. CPT). More importantly, within and between condition effect sizes were published for all three of the non-inferiority trials. It's the effect sizes that are most critical when evaluating the effectiveness of an intervention. What makes the decision to classify WET as insufficient evidence even more perplexing is that the practice guidelines states that the evidence indicates no difference between WET and recommended PTSD treatments of PE and CPT. How can WET be equally effective as PE and CPT, yet the guidelines consider the evidence to recommend WET as insufficient? I do agree that more evidence is always better, but how many RCT studies needs to be published for a treatment to be recommended by the guidelines. I fear that the bar that has been established is one that ensures that all treatments that have come out after 2010 will never be recommended (due to decisions needing TAU or waitlist comparison conditions).	Thank you for your comments. The APA GUP also experienced frustration with the state of the research on WET, an intervention clearly promising in the treatment of PTSD. Because the APA guideline development process relies on systematic reviews that meet IOM standards (2011b), AMSTAR (Shea et al., 2017), Agency for Healthcare Research and Quality (2023) or Cochrane (Higgins et al., 2024) criteria, the availability of additional RCTs would not have contributed to a change in the recommendations at this time. The GUP hopes more high-quality research will enable future panels to make more definitive recommendations. **References** Agency for Healthcare Research and Quality. (2023, September 21). *Methods guide for effectiveness and comparative effectiveness reviews*. Link Higgins, J. P. T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2024). *Cochrane handbook for systematic reviews of interventions* (Version 6.5). https://training.cochrane.org/handbook

Commenter (Group or Individual?)	Section	Comment	Panel Response
			Institute of Medicine. (2011b). *Finding what works in health care: Standards for systematic reviews*. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuku, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ, 358*, Article j4008. https://doi.org/10.1136/bmj.j4008
Jennifer Medicus (Group: American Psychiatric Association)	Treatment Recommendations	The statement on WET vs. other active interventions required careful reading and comparison of the statements to determine why it was pulled out separately, particularly because WET did not have independent evidence of efficacy. The rationale did provide that context, but the bottom line was that no recommendation could be made so perhaps this could be grouped with the other comparisons in the subsequent block.	Thank you for your comments. The APA GUP also experienced frustration with the state of the research on WET, an intervention clearly promising in the treatment of PTSD. Because the APA guideline development process relies on systematic reviews that meet IOM standards (2011b), AMSTAR (Shea et al., 2017), Agency for Healthcare Research and Quality (2023) or Cochrane (Higgins et al., 2024) criteria, the availability of additional RCTs would not have contributed to a change in the recommendations at this time. The GUP hopes more high-quality research will enable future panels to make more definitive recommendations.

Commenter (Group or Individual?)	Section	Comment	Panel Response
			References Agency for Healthcare Research and Quality. (2023, September 21). *Methods guide for effectiveness and comparative effectiveness reviews*. Link Higgins, J. P. T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2024). *Cochrane handbook for systematic reviews of interventions* (Version 6.5). https://training.cochrane.org/handbook Institute of Medicine. (2011b). *Finding what works in health care: Standards for systematic reviews*. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuku, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ, 358*, Article j4008. https://doi.org/10.1136/bmj.j4008

Commenter (Group or Individual?)	Section	Comment	Panel Response
Jessica Hamblen (Individual)	Treatment Recommendations	PCT and WET have more evidence than many of the other treatments under insufficient	Thank you for your comments. The APA GUP also experienced frustration with the state of the research on WET, an intervention clearly promising in the treatment of PTSD. Because the APA guideline development process relies on systematic reviews that meet IOM standards (2011b), AMSTAR (Shea et al., 2017), Agency for Healthcare Research and Quality (2023) or Cochrane (Higgins et al., 2024) criteria, the availability of additional RCTs would not have contributed to a change in the recommendations at this time. The GUP hopes more high-quality research will enable future panels to make more definitive recommendations. **References** Agency for Healthcare Research and Quality. (2023, September 21). *Methods guide for effectiveness and comparative effectiveness reviews*. Link Higgins, J. P. T., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2024). *Cochrane handbook for systematic reviews of interventions* (Version 6.5). https://training.cochrane.org/handbook

Commenter (Group or Individual?)	Section	Comment	Panel Response
			Institute of Medicine. (2011b). *Finding what works in health care: Standards for systematic reviews*. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuku, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ, 358*, Article j4008. https://doi.org/10.1136/bmj.j4008

Section 8: Pharmacological Treatments for PTSD

Commenter (Group or Individual?)	Section	Comment	Panel Response
Mary Burke (Individual)	Treatment Recommendations	Your guidelines for pharmacotherapy represent an overly simplistic approach to PTSD and should be either deferred or greatly expanded. PTSD includes a diverse set of syndromes and symptoms that do not uniformly respond to this small selection of medications. On the other hand, that does not mean we should abandon pharmacology. There have been multiple smaller studies and reviews which look at the complex physiology and treatment approaches that should be incorporated. Failure to do so engenders hopelessness, as less than 30% will achieve remission from the "usual supects" listed in your TPG's. (Kelmendi et al, 2017: Link;) 1. You fail to distinguish between PTSD with hyper-reactive vs hypo-reactive vs chronic/ flattened and dissociated presentations. These presentations must be addressed specifically and individually. 2. Many if not most people cannot tolerate venlafaxine and paroxetine--the weight gain and severe wirthdrawal if a dose is missed or delayed immediately leads people to stop using them. Many people have sexual side effects. SSRI's can cause flatness, which is anti-therapeutic for those who experience pervasive dissociation. People become alienated from psychiatric care because of the uncritical use of these medications.	Thank you for your detailed feedback on the pharmacotherapy guidelines for PTSD. We agree that these are important areas for further consideration, especially regarding the complex and varied presentations of PTSD and the limitations of our current medication options. We respond to each of your points below. 1. You are right. There are individual differences in how individuals with PTSD may respond to pharmacotherapy. There is not a “one-size-fits-all” approach to address common symptoms such as difficulties with emotion regulation, including dissociation, etc. The panel will consider expanding the pharmacotherapy section. 2. Venlafaxine and paroxetine are often first-line interventions due to established efficacy, but they do present side effect challenges, which can indeed be barriers to adherence. Both SSRI's potential emotional blunting and withdrawal effects of the SNRIs can make these less suitable for some patients. One goal is to be transparent

Commenter (Group or Individual?)	Section	Comment	Panel Response
		3. Many of my patients have failed SSRI's and SNRI's and are seeking only something for sleep. Addressing nighttime anxiety and insomnia/ nightmares with medication and behavioral interventions can be more effective with fewer side effects. Broadening the list of potential medications can lead to better remission. Weber and Wetter, 2022. doi: 10.1159/000517329 Options include trazodone and prazosin for insomnia/ nightmares; mirtazapine for insomnia, loss of appetite, depression and anxiety; bupropion or vilazodone for those with chronic depression related to multiple traumas; gabapentin for anxiety. While the evidence is not powerful for this broader selection, this is partly due to lack of studies. See the review by Akiki and Abdallah: Link.	especially given that some patients may already feel alienated from psychiatric care. 3. As alluded to, the panel focused on interventions specifically for the efficacy of treating PTSD severity/diagnosis and not for its efficacy of addressing sleep problems by themselves, though very common in PTSD. Considering alternatives like trazodone, prazosin, and mirtazapine, as well as others you mentioned, broadens the range of potential interventions and aligns with a more individualized approach. While, as you noted, the evidence for these alternatives may be limited by the scope of research, an individualized approach utilizing these and other options, while appropriately weighing the PTSD efficacy data to date, should be often be considered when sleep problems remain or are functionally impairing in and of themselves.
Allison Gillens (Group: APA CECP)	General Comments	Regarding pharmacological treatments for PTSD, a brief discussion on guidelines or the recent findings surrounding psilocybin assisted therapy, ketamine-assisted therapy, and prazosin for nightmares (given its wide usage) in alignment with current discussions and trends should be discussed earlier on. This is brought up in future research needs but the state of the	Thank you for your comment. Randomized controlled trials of psilocybin-assisted and ketamine-assisted psychotherapy are limited at present and were not included in the systematic reviews reviewed. The committee reviewed the role of prazosin for its effects on PTSD but not specifically on efficacy on nightmares alone, as

Commenter (Group or Individual?)	Section	Comment	Panel Response
		literature currently would be best included in the treatment section to avoid confusion.	that was beyond the PICOTS scope of the guidelines.
Paula Schnurr (Individual)	Treatment Recommendations	It is not clear why the evidence for benzodiazepines is insufficient. It is clear that the RCT evidence is insufficient, but the evidence of harm is significant. Other medications in the insufficient category also have harms that resulted in some being suggested against in the VA/DoD guideline. IT is not clear why harms did not factor more significantly into the rating. The suggest against for a single medication does not reflect the state of the evidence.	Thank you for your comment. We appreciate the opportunity to reflect on the harms of these medications given the lack of clear evidence for effectiveness in the use of PTSD. Our panel has reconvened and adjusted our recommendation for benzodiazepines to "Conditional Against."
Julie Ording (Group: ACOEM; Les Kertay, PhD, ABPP)	Treatment Recommendations – Medications	There are differences in recommendations for medications. I have captured the differences (and the important similarities) for reference. Overall, the differences regarding benzodiazepines, bupropion, vilazodone, and gabapentin may be important because they are not recommended with evidence in the ACOEM guideline, but are either not addressed or listed as insufficient evidence by APA – if there is evidence of potential harm, these are worth considering. Other differences that involve "insufficient evidence" by APA but are recommended by ACOEM may be important since there is evidence cited by ACOEM to suggest they are potentially helpful. To reiterate, as medications are not my area of expertise, my review is restricted to differences in the findings in relation to cited evidence. The APA is encouraged to consider any relevant input from other reviewers and may at least wish to review the differences in the chart below.	Thank you for your thorough and thoughtful comment. We appreciate the concern regarding differences in recommendation across different guidelines. These can often be explained by the differences in methodology agreed upon by the leading organization and the expert panel. Ultimately, we hope that these guidelines will complement each other and that readers will be able to enhance their clinical practice based on the different data emphasized and clinical recommendations made. For a summary of the APA guidelines methodology, please refer to the Processes and Methods section in the guideline document.

Commenter (Group or Individual?)	Section	Comment	Panel Response

Medication	**APA Recommendation**	**ACOEM Recommendation**
Fluoxetine, paroxetine, and sertraline, and venlafaxine	all listed as second-line treatments (conditional for)	All are recommended, although fluoxetine is listed as recommended but with insufficient evidence
Olanzapine	Insufficient evidence	Recommended, evidence C
Quetiapine	Insufficient evidence	Recommended, insufficient evidence
Mirtazapine	Insufficient evidence	Moderately recommended, evidence B
Alprazolam	Insufficient evidence	All benzodiazepines are not recommended, evidence C
Phenelzine	Insufficient evidence	Recommended, evidence C

Commenter (Group or Individual?)	Section	Comment			Panel Response
		Bupropion	Insufficient evidence	Not recommended, evidence C	
		Nefazodone	Insufficient evidence	Recommended, evidence C	
		Citalopram	Insufficient evidence	Recommended, evidence C (escitalopram is not referenced by APA, whereas ACOEM recommended with insufficient evidence	
		Prazosin	Insufficient evidence	Recommended, insufficient evidence	
		Topiramate	Conditional against	No recommendation, insufficient evidence	
		Vilazodone	Not addressed	Not recommended, evidence C	
		Gabapentin	Not addressed	Not recommended, evidence C	

Commenter (Group or Individual?)	Section	Comment	Panel Response
		Cannabis-related treatments / Not addressed / No recommendation Ketamine, MMDA / Insufficient evidence / Not addressed Fluoxetine, paroxetine, and sertraline, and venlafaxine / all listed as second-line treatments (conditional for) / All are recommended, although fluoxetine is listed as recommended but with insufficient evidence Olanzapine / Insufficient evidence / Recommended, evidence C Quetiapine / Insufficient evidence / Recommended, insufficient evidence Mirtazapine / Insufficient evidence / Moderately recommended, evidence B Alprazolam / Insufficient evidence / All benzodiazepines are not recommended, evidence C	
Anica Pless Kaiser (Group: SHARP at VA	General Comment	4. There do not appear to be any recommendations regarding medication based on age - Line 343 could be a place to mention age as an important factor to consider in prescribing	Thank you for bringing our attention to this important issue. We have added a bullet point in the implementation considerations section

Commenter (Group or Individual?)	Section	Comment	Panel Response
Boston Healthcare System)		medications. Especially with older adults, it is necessary to carefully review their medications, so as to prevent unfortunate medication interactions.	emphasizing caution on the use of pharmacotherapy in medically complex and older adult populations, and we have added a citation that can be used for further reference for clinicians looking for specific information than what general treatment guidelines can offer.
Jessica Hamblen (Individual)	Treatment Recommendations	Consider whether the harms associated with benzos might move it to rec against.	Thank you for your comment. We appreciate the opportunity to reflect on the harms of these medications given the lack of clear evidence for effectiveness in the use of PTSD. Our panel has reconvened and adjusted our recommendation for benzodiazepines to “Conditional Against.”

Section 9: Contextualized Science

Commenter (Group or Individual?)	Section	Comment	Panel Response
Haniyeh Amini (Individual)	Contextualized Science	First of all I must say that the seed of contextualized science was planted in my mind and soul by reading Dr. Gabor Mate's book: The Myth of Normal. However before that, even as a medical student, I could clearly see that evidence based medicine doesn't work when it comes to mind and spirit. We are living individuals with bodies who always keep the record of everything that happens to us(book by Bessel van der Kolk), minds that store everything in subconscious, and spirits. Most importantly we have integrated connections with each other and the rest of the universe by the micro-connections that can't be seen with naked eyes, but can be felt with open hearts and sensed by our guts. When something happens to a person, it affects all that mentioned in a way that can only be understood by a contextual and integrated perspective. I'm only a student, and don't have much experience and knowledge, but I've worked with people and helped them overcome PTSD and other mental challenges. One thing that's very important: PTSD is not a label you put on someone and then approach to it, we're trying to help real people not labeled robots. I used to read academic books, use their evidences to help people, but it only affected the surface and made everything worse deep down: let the trauma be your teacher not an enemy. Instead of telling them what to do to be "fixed", listen to what they say, learn from the patient as Dr.Irvin D. Yalom says, let them create their authentic path to healing by facing the darkness inside. What do we do? We're there to help them if the pressure is too much to bear, to support them in their healing path. We are all alike, we have traumas ourselves, we've been hurt too. So seeing the patient from a top down	Thank you for your comment! It is great to know that individuals such as yourself, who are the future of healthcare, are as enthusiastic and caring about contextualized science as we are. The panel in conjunction with the Advisory Steering Committee (ASC) for APA's clinical practice guidelines has been working to better incorporate this into the current guideline as well as working on plans to further and expand this in future guidelines and related products. In the current guideline the panel strived to address this by making related recommendations in the implementation considerations and recommendations for future research section (new recommendation sections recently added by the ASC), include more information about diversity of included samples, include information on the applicability (generalizability) of each recommendation, and include broader discussion of these issues in the discussion and future directions. Members with lived experience (community members) are also always included on each clinical practice guideline development panel. The ASC is also actively considering ways to further contextualized science such as by: using a

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		perspective will not help neither of us. Just stop putting labels and using outdated approaches to cure people. Each person, besides all the similarities they have with all humanity and universe, is a unique force of life. Their journey, their lived experiences and the context of life that raised them to be who they are today, is unique. How do you expect them to heal with a same single approach? I still don't know how can we do this, but I have no doubts that this is the right path to authentic healing. Children, adolescents and women need a more personalized, integrated approach to healing and reaching their fullest potential. Please hear our voice, the future of our community needs to change, and that change starts today, with a single vote: your vote, my vote, our votes.	roadmap with guidance from the beginning when a topic is considered all the way to the end, exploring other types of literature such as qualitative research and the types of questions it can address, development of decision aids to accompany each clinical practice guideline and better contextualize the guidance with the broader evidence based practice and together with other population specific guidance, and exploring the development of other types of evidence based products that could allow for the use of contextualized science. Thank you again for feedback!
Tamey Greene (Individual)	Contextualized Science	As a practitioner, veteran, and Director of Veteran Stress Solution with extensive experience in the mental health field, I believe it is critically important for psychology and the broader mental health field to integrate contextualized science that authentically includes the complex diversities and lived experiences of people. This approach would significantly benefit APA's future guideline development in several key ways: 1. Enhancing Relevance and Effectiveness Integrating contextualized science that considers diverse lived experiences would make psychological research and interventions more relevant and effective for a wider range of populations. By accounting for cultural, social, and environmental factors that shape individuals' experiences and behaviors, we can develop more nuanced and applicable theories and treatments15.	Thank you very much for your service to our country, to your fellow veterans, and for taking the time to share this wonderful feedback! It was heartwarming to read, and it is so nice to see that you share our same enthusiasm for contextualized science. The panel in conjunction with the Advisory Steering Committee (ASC) for APA's clinical practice guidelines has been working to better incorporate this into the current guideline as well as working on plans to further and expand this in future guidelines and related products. In the current guideline the panel strived to address this by making related recommendations in the implementation considerations and recommendations for

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		2. Improving Cultural Competence A contextualized approach would enhance cultural competence in the field, leading to better understanding and treatment of individuals from diverse backgrounds2. This is particularly important when working with historically underserved or marginalized populations, who may have unique needs and perspectives that are often overlooked in traditional research paradigms2. 3. Addressing Health Disparities By considering contextual factors, we can better understand and address health disparities among different populations25. This approach would allow for the development of more targeted and effective interventions to improve mental health outcomes across diverse communities. 4. Promoting Scientific Rigor Incorporating diverse perspectives and experiences into psychological research would enhance scientific rigor by providing a more comprehensive understanding of human behavior and mental processes13. This approach would help identify potential biases and limitations in existing research and lead to more robust and generalizable findings. 5. Informing Evidence-Based Practice A contextualized approach would strengthen the evidence base for psychological interventions by considering how different factors influence treatment outcomes across various	future research section (new recommendation sections recently added by the ASC), include more information about diversity of included samples, include information on the applicability (generalizability) of each recommendation, and include broader discussion of these issues in the discussion and future directions. Members with lived experience (community members) are also always included on each clinical practice guideline development panel. The ASC is also actively considering ways to further contextualized science such as by: using a roadmap with guidance from the beginning when a topic is considered all the way to the end, exploring other types of literature such as qualitative research and the types of questions it can address, development of decision aids to accompany each clinical practice guideline and better contextualize the guidance with the broader evidence based practice and together with other population specific guidance, and exploring the development of other types of evidence based products that could allow for the use of contextualized science. Thank you again for the feedback!

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		populations and settings36. This would lead to more nuanced and effective guidelines for evidence-based practice. 6. Enhancing Ecological Validity By including diverse lived experiences in research and guideline development, we can improve the ecological validity of psychological theories and interventions5. This would ensure that our understanding of mental health and behavior is more reflective of real-world contexts and experiences. 7. Fostering Innovation Integrating diverse perspectives and experiences can spark innovation in research methodologies and intervention strategies56. This approach may lead to the development of novel approaches that are better suited to address complex mental health challenges in diverse populations. 8. Improving Guideline Development For APA's future guideline development, adopting a contextualized approach would result in more comprehensive and inclusive guidelines4. These guidelines would better account for the diverse needs of different populations and provide more flexible and adaptable recommendations for practitioners. 9. Enhancing Implementation By considering contextual factors in guideline development, we can improve the implementation and adoption of evidence-based practices across diverse settings6. This would help bridge	

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		the gap between research and practice, ensuring that psychological interventions are more effectively translated into real-world applications. In conclusion, integrating contextualized science that authentically includes diverse lived experiences is crucial for advancing the field of psychology and mental health. This approach would lead to more relevant, effective, and equitable mental health care, benefiting both practitioners and the individuals they serve. For APA's future guideline development, this integration would result in more comprehensive, inclusive, and applicable guidelines that better serve the needs of diverse populations and contexts.	